State Employee Health Plan Administrative Manual Non State Employers Plan Year 2014

CHAPTER 1 – GENERAL HEALTH PLAN INFORMATION

The information provided in this manual is subject to change without prior notice. SEHP staff will reasonably attempt to notify NSE HR offices when changes have been made; however, NSE HR offices should not rely solely on being updated of changes by SEHP staff. NSE HR offices are advised they should check the SEHP website to verify they are using the most up to date version of this manual.

I. GENERAL HEALTH PLAN INFORMATION

The State Employee Health Plan (SEHP) is authorized by K.S.A. 75-6501 et seq. The program is governed by the State of Kansas Employees Health Care Commission which is comprised of the following five members:

- The Secretary of the Kansas Department of Administration
- The Kansas Insurance Commissioner
- A retiree from classified State of Kansas service (appointed by the Governor)
- An active employee from classified State of Kansas service (appointed by the Governor)
- A person from the general public (appointed by the Governor)

The HCC has created a Non State Employer (NSE) health care benefit plan to provide health care benefits within the SEHP benefits program. The intent of this is to allow the NSE to participate in a health benefit risk pool, which is comprised of entities enumerated in K.S.A. §75-6506(c) and other amendments. The HCC and SEHP Commission provide professional benefit administration of the health plan.

Generally, the State of Kansas bids and contracts with health plans for three year periods. The component parts (medical, prescription drug, dental and vision) are staggered so that not all contracts come due the same year.

The State Employee Health Plan self-insured medical plans for active employees are:

- **Blue Cross Blue Shield of Kansas** (Plan A, Plan B, and Plan C-Qualified High Deductible Health Plan with Health Savings Account),
- **Coventry** (Plan A, Plan B and Plan C-Qualified High Deductible Health Plan with Health Savings Account),
- **United Healthcare** (Plan A, Plan B and Plan C-Qualified High Deductible Health Plan with Health Savings Account)

Other health plan benefits available under the SEHP:

- **CVSCaremark** provides the self-insured prescription drug coverage.
- **Delta Dental Plan of Kansas** administers the dental plan.
- **Superior Vision** administers the fully insured voluntary vision plan.
- **US Bank** administers the Health Saving Accounts for Plan C
- **COBRAGuard** administers the COBRA (Consolidated Omnibus Budget Reconciliation Act).

For each self-insured plan, the SEHP pays the plan provider an administrative fee per contract to process membership and claims. The SEHP and plan members are therefore directly responsible for all claims and utilization costs.

II. GENERAL DEFINITIONS

A. ***COBRA Participant*** - A participant who elects a temporary extension of health coverage, where such coverage would otherwise end, as defined by the COBRA act of 1986.

B. ***Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986*** - A Federal law requiring that most employers sponsoring Group Health Insurance Plans offer employees and their families an opportunity to extend health coverage for a limited period of time.

C. ***Dependent*** - Any of the primary member's eligible dependent child(ren) as defined in KAR 108-1-3 and 108-1-4

D. ***Direct Bill and Retirees*** - A program to extend health coverage to:

- retiring participating state employees,
- totally disabled former participating state employees,
- surviving spouses and/or dependents of participating state employees eligible under the provisions of K.A.R. 108-1-3 and 108-1-4
- active participating state employees who were covered under the health plan immediately before going on approved leave without pay.

E. ***Educational Employer Group*** (See also Qualified School district)—a public school district, community college, area vocational technical school, or technical college that meets the terms, conditions and other provisions established by the HCC and has entered into a written agreement with the HCC to participate in the SEHP.

F. ***Employee Contribution Rate*** - The premium amount paid by the employee for their SEHP coverage.

G. ***Employer Contribution Rate*** - The premium amount paid by the employer on behalf of the employee and/or dependents.

H. ***Full-time Educational Employer Group*** (Qualified School District) Employee—the individual is an appointed or elective officer or employee of an educational employer group whose employment is not seasonal or temporary and whose employment requires at least 1,000 hours of work per year.

I. ***Full-time Local Unit Employee***—the individual is an appointed or elective officer or employee of a qualified local unit whose employment sis not seasonal or temporary and whose employment requires more than 2,000 hours of work per year.

J. ***Health Care Commission (HCC)*** - The entity that establishes and oversees all provisions under the State Employee Health Plan.

K. ***Health Plan*** - Defined medical, drug, dental and vision benefits offered to the State of Kansas employees.

L. ***HealthQuest*** - The State of Kansas Health Promotion Program, which is a wellness program administered by the State Employee Health Plan.

M. ***Health Insurance Portability and Accountability Act (HIPAA)*** – the federal act which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

N. ***Local unit or entity***—any of the following:

1) Any county, township, or city
2) Any community mental health center;
3) Any groundwater management district, rural water-supply district, or public wholesale water-supply district;
4) Any county extension council or extension district;
5) Any hospital established, maintained, and operated by a city of the first or second class, a county, or a hospital district in accordance with applicable law;
6) Any city, county, or township public library created under the authority of K.S.A. 12-1215 et seq., and amendments thereto;
7) Any regional library created under the authority of K.S.A. 12-1231, and amendments thereto;
8) Any library district created under the authority of K.S.A. 12-1236, and amendments thereto;
9) The Topeka and Shawnee county library district established under the authority of K.S.A. 12-1260 et seq., and amendments thereto;
10) The Leavenworth and Leavenworth county library district established under the authority of K.S.A. 12-1270, and amendments thereto;
11) Any public library established by a unified school district under the authority of K.S.A. 72-1623, and amendments thereto; or
12) Any regional system of cooperating libraries established under the authority of K.S.A. 75-2547 et seq., and amendments thereto;
13) Any housing authority created pursuant to K.S.A. 17-2337 et seq., and amendments thereto;
14) Any local environmental protection program obtaining funds from the state water fund in accordance with K.S.A. 75-5657, and amendments thereto;
15) An city-county, county, or multicounty health board or department established pursuant to K.S.A. 65-204 and 65-205, and amendments thereto;
16) Any nonprofit independent living agency, as defined in K.S.A. 65-5101 and amendments thereto;
17) The Kansas guardianship program established pursuant to K.S.A. 74-9601 et seq., and amendments thereto; or
18) Any group of persons on the payroll of a county, township, city, special district or other local governmental entity, public school district, licensed child care facility operated by a not-for-profit corporation providing residential group foster care for children and receiving reimbursement for all or part of this care from the department of social and rehabilitation services, nonprofit community mental health center pursuant to K.S.A. 19-4001 et seq. and amendments thereto, nonprofit community facility for the mentally retarded pursuant to K.S.A. 19-4001 et seq. and amendments thereto, or nonprofit independent living agency as defined in K.S.A. 65-5101K.S.A. 65-5101 and amendments thereto.

O. ***Local unit/entity plan***—the local unit/entity employee health care benefits component of the heath care benefits program.

P. ***Member*** - Individual who is eligible for and actively participates in the health care benefits offered through the State Employee Health Plan. This includes employees, spouses and children.

Q. ***Membership Services*** - The State Employee Health Plan unit responsible for all daily management of all eligibility functions and membership activities for all members who participate in the State Employee Health Plan. Members include Active state employees,

Non State Public Employer Group employees, Retirees, Direct Bill members and COBRA participants. The unit is also involved in managing and securing contracts with vendors that provide administrative services related directly to Membership programs.

R. ***Non State Health Benefits Risk Pool***—a defined group of employees that are experience rated.

S. ***Open enrollment period*** - The period of time during which all members of the SEHP have the opportunity to enroll in and make plan changes to their SEHP. Open enrollment is only held once a year during the month of October. If a member misses the SEHP's annual open enrollment period, the member will not be able to enroll in or make any plan changes to their SEHP coverage until the next annual open enrollment period. Certain exceptions apply for new employees or employees with midyear qualifying events.

T. ***Plan year*** – The annual time period for benefits in the SEHP, beginning at 12:01 a.m. (CST) on January 1st and ending at midnight (CST) on December 31st.

U. ***Premium***—the total cost of the health plan option selected by the employee.

V. ***Primary member*** – The individual who is the person actively employed with the State of Kansas. In the event of retirement—the primary member is the main participant in the coverage and is not considered a dependent of another active primary member.

W. ***Qualified school district***—a public school district, community college, area vocational technical school or technical college that meets the terms, conditions and other provisions established by the HCC and has entered into a written agreement with the HCC to participate in the SEHP.

X. ***Qualified Medical Child Support Order (QMCSO) –*** A qualified medical child support order. (QMCSO) is designed to provide health coverage to a child of an employee through his or her employer's group health plan. The QMCSO process occurs through the court system. A medical child support order becomes qualified as a QMCSO if it satisfies the employer's legal and administrative qualification requirements. The Employee Retirement Income Security Act of 1974 (ERISA) and the employer's group health plan guide the employer's QMCSO process.

A 1993 amendment to the Employee Retirement Income Security Act (ERISA) requires employer-sponsored group health plans to extend health care coverage to the children of a parent/employee who is divorced, separated, or never married when ordered to do so by state authorities.

Y. ***Ramp Up***—the alternative method for an employer to reach the funding level that is at least equal to the contribution made for State employees and dependents in the SEHP.

Z. ***School district plan***—the school district employer health care benefits component of the health care benefits program.

AA. ***State Employee Health Plan (SEHP)*** - The state health care benefits program that may provide benefits for persons qualified to participate in the program for medical, prescription drug, dental, vision and other ancillary benefits to State of Kansas eligible employees and their eligible dependents. The program may include such provisions as are established by the Kansas state employees' health care commission, including but not limited to qualifications for benefits, services covered, schedules and graduation of benefits, conversion privileges, deductible amounts, limitations on eligibility for benefits

by reason of termination of employment or other change of status, leaves of absence, military service or other interruptions in service and other reasonable provisions as may be established by the commission.

Questions about the administration of and membership in the SEHP should be directed to the following address:

State Employee Health Plan
Membership Services
Room 900 – Landon State Office Building
900 SW Jackson Street
Topeka, Kansas 66612-1220
Telephone: (785) 296-3226
Fax: (785) 368-7180
benefits@kdheks.gov

Visit our website at: www.kdheks.gov/hcf/sehp/default.htm

NOTE:

Non State Employer (NSE) Human Resources (HR) Representatives must ensure that current valid employee addresses are on file with SEHP Membership Services. It is important that current addresses are maintained by the NSE HR Representative in the Kansas employee eligibility portal (KEEP) so that employees can receive health plan information timely.

The Appendices of this manual contain the current forms and other important information.

If you have specific questions regarding areas within the SEHP, please contact the respective staff in the table on the next page

2014 STATE EMPLOYEE HEALTH PLAN CONTACT LIST

MEMBERSHIP SERVICES			
Judy Crawford	Sr. Admin. Specialist	785-296-3226	JCrawford@kdheks.gov
Sarah Beck	Benefits Consultant NSE Groups & COBRA	785-296-0880	SBeck@kdheks.gov
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Zaq Rood	Benefits Consultant FSA & HSA Coordinator	785-368-6341	ZRood@kdheks.gov
Brenda Vaughn	SOK Active Employee Specialist	785-296-3147	BVaughn@kdheks.gov
Lea Weishaar	SOK Active Employee Specialist	785- 296-0611	LWeishaar@kdheks.gov
Cindy Miller	Senior Manager	785-368-6578	CAMiller@kdheks.gov
Health Savings Account Vendor	***USBank***	*877-470-1771*	*www.mycdh.usbank.com/*
COBRA Billing Vendor	***COBRAGuard***	*866-952-6272*	*participant.services@cobraguard.net*
NSE Premium Billing Vendor	***HP Enterprise Services***	*866-688-5009*	*https://express.openbill.com/khpa/enroll.html*
DIRECT BILL / RETIREES MEMBERSHIP SERVICES			
DIRECT BILL Phone Line		866-541-7100 **(Toll Free) or** 785-296-1715 **(Topeka Area)**	
Deb Dumas	Direct Bill Specialist	785-291-3126	DDumas@kdheks.gov
Laura Smith	Direct Bill Specialist	785-291-3264	LBSmith@kdheks.gov
Premium Billing Vendor	***HP Enterprise Services***	*866-688-5009*	*https://express.openbill.com/khpa/enroll.html*
Medicare Rx Vendor	**First Health Part D**	*888-736-3133.*	TBD
HEALTH PLAN OPERATIONS			
Melody Connell	Benefits Consultant	785-368-6533	MConnell@kdheks.gov
Jeanne Kelly	Non State Employer Group Coordinator	785-296-6205	JKelly@kdheks.gov
HEALTH MANAGEMENT (WELLNESS)			
Julie Faust	Wellness Communications Coordinator	785-296-5624	JFaust@kdheks.gov
Wellness Program Vendor - ALERE	*Marissa Kalkman,* *Onsite Program Manager*	*785-296-8198*	*Marissa.Kalkman@alere.com*

CHAPTER 2 – NON STATE EMPLOYER GROUP ELIGIBILITY

I. NON STATE EMPLOYER GROUP DEFINITION

As defined by the HCC, Non State Employer(NSE) groups may include, but are not limited to the following: qualified school districts, community colleges, area vocational technical schools, or technical colleges, special districts or other local governmental unit or entity; persons on the payroll of a county, township, city, county extensions, hospitals (city, district, or community), libraries, and community mental health centers as outlined in Supp. 2005 K.S.A. 75-6506(c) and supporting regulations.

II. PARTICIPATION REQUIREMENTS

In order for a Non State Employer to qualify to participate in the SEHP:

A. A minimum of 70 percent of all benefits eligible employees must be enrolled in the SEHP. Non State Employers will certify their compliance with the 70 percent enrollment each year.

B. Plan design and funding are determined by the HCC and are not subject to negotiation.

C. The State requires Non State Employers to sign a contract to participate for a minimum of 3 years. If the Non State Employer qualifies for a financial option (premium ramp up), the participation in the plan is required for a minimum of five years.

D. Non State Employers may not create, maintain or provide incentives for employees not to join the SEHP. Non State employers may not permit any exemption from participation in the SEHP for their group's employees. This prohibition includes Internal Revenue Code Section 125 cash out options.

E. The SEHP must be considered a "core" benefit in the Non State Employer's cafeteria benefit plan.

F. The rate of the premium paid by the Non State Employer shall at least equal the rate paid by the State of Kansas for its employees.

G. Non State Employers must contribute toward and participate in HealthQuest, the state's health wellness program. Each employer must provide a contact person and must participate in HealthQuest initiatives.

H. Non State Employers must provide staff for enrollment, general information and first level assistance to employees and members.

I. Non State Employers must adhere to the established administrative processes and procedures set up by the Health Care Commission.

J. Non State Employer groups joining the SEHP after the beginning of the Plan Year will incur the plan deductibles and coinsurance beginning on the effective date of the group in the plan. Deductible and coinsurance do not carry over and must be met for

each Plan Year (January 1-December 31).

NOTE:
Please refer to the "State of Kansas Non State Public Employer Contract" for additional requirements and provisions.

CHAPTER 3 – EMPLOYEE ELIGIBILITY

I. EMPLOYEE DEFINITION—ACTIVE PARTICIPANTS

According to provisions of K.A.R. 108-1-3 (see **Appendix A-1**) and K.A.R. 108-1-4 (see **Appendix A-2**), the classes of persons eligible to participate in the State Employee Health Plan as Active Participants shall be the following classes of persons:

A. Educational Employer Group/Qualified School District employee—any individual who is employed by an education employer group/qualified school district and who meets the definition of employee under K.S.A. 74-4932(4), and amendments thereto, whose employment is not seasonal or temporary and requires at least:

1. 630 hours of work per year for part-time status or;

2. 1,000 hours of work per year for full-time status

B. Qualified Local unit employee—any individual who meets one or more of the following criteria:

1. The individual is an appointed or elective officer or employee of a qualified local unit whose employment is not seasonal or temporary and whose employment requires at least 1,000 hours of work per year.

2. The individual is an appointed or elective officer or employee who is employed concurrently by two or more qualified local units in positions that involve similar or related tasks and whose combined employment by the qualified local units is not seasonal or temporary and requires at least 1,000 hours of work per year.

3. The individual is a member of a board of county commissioners of a county that is a qualified local unit, and the compensation paid for service on the board equals or exceeds $5,000 per year.

4. The individual is a council member or commissioner of a city that is a qualified local unit, and the compensation paid for service as a council member or commissioner equals or exceeds $5,000 per year.

Eligible active employees who elect to participate shall be referred to as member(s) throughout the rest of this manual. The term SEHP means the State Employee Health Plan.

II. EMPLOYEE WAITING PERIOD

Each person who is within a class listed in paragraphs A-B above whose first day of work for the qualified school district or local unit is on or after the first day on which the qualified school district or local unit participates in the school district or local unit plan shall become eligible for coverage following the completion of a 30-day waiting period beginning with the first day of work for the qualified school district or local unit.

Each employee will have 31 days from their first day of employment with a qualified school district or local unit to elect or waive SEHP coverage via the online Kansas employee eligibility portal **(KEEP)**. For those enrolling in the SEHP, their coverage will be effective the

first day of the month following completion of the 30-day waiting period starting from their first day of employment with the qualified school district or local unit. If a new employee misses this deadline, coverage will be waived by default, and the next opportunity to elect coverage will be during the annual SEHP Open Enrollment period.

Online Enrollment or Change requests submitted without the appropriate supporting documentation as outlined in **Chapters 4 and 12** will be denied with no action taken by the SEHP. All documentation must be in the English language. The deadline for submitting the enrollment/change requests will not be extended.

1. The waiting period established above will not apply if all of the following conditions are met:

A. The person is returning to work for the qualified school district or local unit, transferring from another qualified school district or local unit, or is transferring from a position that is eligible for coverage under K.A.R. 108-1-1, K.A.R. 108-1-3 or K.A.R. 108-1-4.

B. Immediately before leaving the prior position, the person was enrolled in and had continuous coverage under the health care benefits program provided by the state of Kansas under K.A.R. 108-1-1, the school district plan under K.A.R. 108-1-3, or the qualified local unit plan under K.A.R. 108-1-4.

C. The break in service between the prior position and the new position does not exceed the following time periods:

1) 30 or fewer calendar days; or

2) 365 or fewer calendar days, if the person was laid off in accordance with the practices of the qualified school district or local unit.

The Non State Employer HR Representative must submit an online Transfer request. The Non State Employer HR Representative should indicate in the notes section of the online enrollment request that the member is a current SEHP member, identify who the current employer is and include the member's employee identification number. Coverage will be effective the first of the month following the date of hire.

2. The waiting period established above will not apply to any person who, on that person's first day of work for the qualified school district or local unit, is enrolled in the health care benefits program provided by the state of Kansas under K.A.R. 108-1-1, the school district plan under K.A.R. 108-1-3, or the qualified local unit plan under K.A.R. 108-1-4 on any of the following bases:

A. The person has had continuous SEHP coverage under the Direct Bill Program. Please refer to **Chapter 18** for complete information on the Direct Bill Program.

The member must complete a new online Enrollment request. The Non State Employer Human Resources Representative should indicate in the notes section of the online enrollment request that the member is a current Direct Bill member

and include the member's employee identification number. Coverage will be effective the first of the month following the date of hire.

B. The person has had continuous SEHP coverage under COBRA. Please refer to **Chapter 20** for complete information on COBRA.

The member must complete a new online Enrollment request. The Non State Employer Human Resources Representative should indicate in the notes section of the online enrollment request that the member is a current COBRA member and include the member's employee identification number. Coverage will be effective the first of the month following the date of hire.

C. The person has had continuous SEHP coverage as a dependent of another member in the health care benefits program.

The member must complete a new online Enrollment request. The Non State Employer HR Representative should indicate in the notes section of the online enrollment request that the member had been covered under their spouse's or parent's SEHP coverage, provide the employee's name and include the member's employee identification number. Coverage will be effective the first of the month following the date of hire.

3. Persons who are changing from a non-benefits eligible position to a benefits eligible position with no more than a 3 day break in service will apply calendar days employed in the previous position towards meeting the 30 day waiting period. Credit toward the 30 day waiting period will be given for time served in a non-benefits eligible position if the transfer to a benefits eligible position occurs with no more than a 3 day break in employment.

Note: Student employee positions are non-benefits eligible positions; therefore, student employees have the 30 day waiting period when moving to a benefits eligible position.

4. Waiver of the Waiting Period

Under certain circumstances, the 30 day waiting period may be waived under the provisions of K.A.R. 108-1-3 **(see Appendix A-1)** and K.A.R 108-1-4 **(see Appendix A-2)**. The chief administrative officer of the qualified school district or local unit must certify in writing, to the Kansas State Employees Health Care Commission (HCC) or its designee that the waiver is being sought for either of the following reasons:

A. The new employee is not entitled to continuation of health benefits under either Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended, or state continuation of coverage laws, K.S.A. 40-2209 and K.S.A. 40-3209 and amendments thereto, and is not covered by or eligible to be covered by another health insurance plan;

B. The new employee is required to have health insurance as a condition of obtaining a work visa for employment in the United States.

The Non State Employer must complete and submit a Request for Waiver of the 30 day Waiting Period Form (see Appendix E) along with the written request for waiver, within 30 days of the date of hire.

If the 30 day waiting period is waived, the employee's contribution must initially be paid on an after-tax basis. An employee may change to the pre-tax premium option effective the first day of the month that their coverage would have become effective without the waiver. If an employee desires to change to the pre-tax option after this period of time, the member must complete a new online Change request. The Non State Employer HR Representative should indicate in the notes section of the online enrollment request the date of the original enrollment request.

5. If the 30 day waiting period is waived, the employee's contribution must initially be paid on an after-tax basis. An employee may change to the pre-tax premium option effective the first day of the month that their coverage would have become effective without the waiver. If an employee desires to change to the pre-tax option after this period of time, the member must complete a new online Change request. The Non State Employer HR Representative should indicate in the notes section of the online enrollment request the date of the original enrollment request.

III. EMPLOYEE'S EFFECTIVE DATE OF COVERAGE

The initial enrollment period for the Health Plan is limited. New employees should complete an online Enrollment request via the online Kansas employee eligibility portal (KEEP) **within 31 days** of their starting date in a benefits eligible position. The effective date of coverage will be the first day of the month following the completion of the waiting period **(see Appendix P—SEHP Coverage Begin Dates)**; providing that the SEHP Membership Services receives the online enrollment request within 31 days from the date of hire in a benefits eligible position. Once benefits have become effective, no changes to the elections may be made unless due to a qualifying event.

For new employees being granted the waiver of the waiting period (see prior section), the effective date of coverage is the first day of the month following the date of hire. If the date of hire is the first day of a month, coverage begins on that day.

For current employees who are changing from a non-benefits eligible position to a benefits eligible position, and who have already served the 30 day waiting period, the enrollment period is 31 days from the date the employee started working in the eligible position. SEHP Membership Services must receive the online Enrollment request within 31 days from the date the employee started working in the eligible position. The effective date of coverage is the first day of the month following the starting date in the eligible position. If the eligible position begins on the first day of the month, coverage begins on that day.

For rehired employees with a break in service of 30 calendar days or less, the effective date of coverage is the first day of the month following the rehire date (if the employee had Health Plan coverage in effect prior to the break in service). If the rehire date is the first day of the month, the coverage effective date will be the first day of that month. If the employee is rehired or reactivated within 30 days, the person must enroll in the same coverage they had previously, unless the person experiences a qualifying event.

IV. PRE-EXISTING CONDITIONS

The SEHP does not apply an additional waiting period for pre-existing conditions.

V. WAIVER OF INSURANCE COVERAGE

If an eligible employee does not elect to enroll in the SEHP, an online Election request must be completed by the employee indicating that they wish to waive SEHP coverage during the employee's initial enrollment period. If the employee does not complete their initial enrollment online within their initial enrollment period, the employee will be set up as waiving all coverage. The next opportunity for the employee to enroll will be pending a mid-year qualifying event or at the next Open Enrollment period.

VI. FULL-TIME/PART-TIME STATUS

Employee contributions for group health insurance during the Plan Year are dependent upon full-time or part-time employment status of the position (benefit program code) as outlined below. If the employee is active in more than 1 eligible position, the employment status should be based on the combined FTE (Full-Time Equivalent) for all positions.

Employment Status (first 2 digits of benefit program code)

LF = Full-Time **(FT)** = 90 to 100% FTE

LP = Part-Time **(PT)** = 50 to 89% FTE

Employment status and benefit program code must be changed during the Plan Year whenever the employee changes from a full-time to a part-time position or from a part-time to a full-time position (as outlined above).

If the employment status change takes place on the first day of a month, the new benefit effective date will be the first day of that month. If the employment status change takes place during the month, the effective date will be the first day of the following month. If changes in SEHP coverage result from these employment status changes, the same effective dates shall apply.

VII. HEALTH PLAN SALARY RANGE

The Health Plan salary range is the range in which an employee's annual salary falls within as of January 1 each year. For new employees hired during the Plan Year, the annual salary is as of the employee's date of hire. For current employees with new benefits eligibility, the annual salary is as of the date of benefits eligibility.

Employee contributions for SEHP coverage during the Plan Year are dependent upon the employee's salary range as outlined below. (If the employee is active in more than 1 eligible position, the annual salary range shall be based on the combined salary for all positions):

Annual Salary Ranges (Plan Year 2014) (3rd digit of benefit program code)

Salary Range 1 = Less than $28,000
Salary Range 2 = $28,000 to $48,000
Salary Range 3 = More than $48,000

The salary range should not be changed during the Plan Year unless the employee's salary range changes due to changing from a full-time to a part-time position or from a part-time to a full-time position **(see Section VI)**.

The SEHP is responsible for updating each employee's salary range each year prior to the beginning of a new Plan Year. During the plan year, the SEHP will only change the salary range for an employee if an employee changes from full-time to part-time status or from a part-time to a full-time position.

Non State Employer Groups will provide the SEHP Membership Services with updated employee salary tiers changes, via email, on a special ID list by **November 15th** each year. All salary tier changes will be effective as of the beginning of the following Plan Year. If the

list is not returned by November 15th, only changes related to a qualifying event will be made for the upcoming plan year.

PLEASE NOTE:

The Qualified High Deductible Health Plan deduction is not dependent on the salary range of the employee.

CHAPTER 4 – OTHER ELIGIBLE INDIVIDUALS FOR THE SEHP

I. OTHER ELIGIBLE INDIVIDUALS INFORMATION

A. In addition to covering themselves, a primary member can also elect coverage for other eligible individuals. These eligible individuals include:

- A lawful wife or husband, referred to as "spouse" throughout the rest of this manual (Same gender marriages are not recognized under Kansas Law).
- Any of the primary member's eligible dependent child(ren) also referred to as "dependent(s)" throughout the rest of this manual.

NOTE: If a primary member divorces, coverage for their former spouse and stepchild(ren) ends on the last day of the month of the date of the divorce. If the date of the divorce is the first day of the month, coverage for the primary member's former spouse and stepchild(ren) ends on the last day of the month prior.

B. An individual who is eligible to enroll as a primary member in the SEHP is not eligible to be enrolled as spouse or dependent of a primary member in the SEHP.

C. An eligible dependent that is enrolled by one primary member is not eligible to be enrolled as a dependent by another primary member.

D. "Other eligible individual" excludes any individual who is not a citizen or national of the United States, unless the individual is a resident of the United States or a country contiguous to the United States, is a member of a primary member's household, and resides with the primary member for more than six months of the calendar year. The dependent shall be considered to reside with the primary member even when the dependent is temporarily absent due to special circumstances, including illness, education, business, vacation, and military service.

E. "Permanent and total disability" means that an individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months. An individual shall not be considered to have permanent and total disability unless the individual furnishes proof of the permanent and total disability in the form and manner, and at the times, the SEHP may require.

F. The word "child" means:

- A natural son or daughter of the primary member
- A lawfully adopted son or daughter of the primary member. Lawfully adopted will include those instances in which a primary member has filed a petition for adoption with the court, has a placement agreement for adoption or has been granted legal custody. Please see Section III. A. below for supporting documentation requirements.
- A stepchild of a primary member. If the natural or adoptive parent of the stepchild is divorced from the primary member, the child no longer qualifies as the primary member's stepchild, and is no longer eligible for coverage.
- A child of whom the primary member has legal custody. Legal custody ends once the child reaches the age of 18.
- A grandchild, if at least one of the following conditions is met:
  a) The primary member has legal custody of the grandchild or has lawfully adopted

the grandchild

b) The grandchild lives in the home of the primary member and is the child of a covered eligible dependent child and the primary member provides more than 50% of the support of the grandchild; or

c) The grandchild is the child of a covered eligible dependent child and is considered to reside with the primary member even when the grandchild or eligible dependent child is temporarily absent due to special circumstances including education of the covered eligible dependent child, and the primary member provides more than 50% of the support for the grandchild.

A Dependent Grandchild affidavit (see **Appendix K**) must be completed and submitted along with a copy of the grandchild's birth certificate.

G. Eligible dependent child(ren) or stepchild(ren). To be covered under the SEHP, the child or stepchild must be less than 26 years of age.

H. Eligible dependent child(ren) or stepchild(ren) aged 26 or older who have a permanent and total disability as described in Section E above and has continuously maintained group coverage as an eligible dependent of the primary member before reaching the limiting age to be covered under the plan. The child must be chiefly dependent on the primary member for support (receive more than 50% of his or her support and maintenance from the primary member.)

An Application for Coverage of Permanent and Totally Disabled Dependent Child (see **Appendix L**) must be completed and submitted to SEHP Membership Services. If approved for continued coverage, medical documentation may be periodically requested. Coverage will not be continued and will not be reinstated once the dependent child is no longer considered permanent and totally disabled.

II. OTHER ELIGIBLE INDIVIDUAL'S EFFECTIVE DATE OF COVERAGE

Other eligible individuals shall become newly eligible on the later of:

A. The primary member's initial date of eligibility; or

B. The first day of the month following the date the individual first becomes an eligible individual of the primary member or becomes newly eligible for coverage according to the spouse or dependent definition. The newly eligible spouse or dependent must be added to coverage within 31 days of the date the primary member gains the new spouse or dependent or within 31 days of the date the spouse or dependent becomes newly eligible according to the spouse or dependent definition. The SEHP Membership Services must receive the Change request and supporting documentation within 31 days of the date the spouse or dependent becomes newly eligible according to the spouse or dependent definition.

C. The first day of the month following the loss of Medicaid or State Children's Health Insurance Program (SCHIP) coverage. The newly eligible spouse or dependent must be added to coverage within 60 days of the date of the loss of Medicaid or SCHIP coverage. The SEHP must receive the online Change request and any supporting documentation within 31 days of the date of loss of Medicaid or SCHIP coverage.

III. PROCESSING NEWLY ELIGIBLE SPOUSE OR DEPENDENTS

All online Enrollment or Change requests adding newly eligible spouse or dependents must be completed and submitted to SEHP Membership Services within 31 days of the event that makes the spouse or dependent newly eligible. Coverage for the newly eligible spouse or dependents may be added if the primary member is enrolled in the SEHP on a pre-tax or an after-tax basis.

The change in coverage must be consistent with the event and/or must comply with HIPAA (Health Insurance Portability and Accountability Act) regulations.

Supporting documentation is required (see list below of appropriate documentation) as proof of the qualifying event. Requests that are submitted without documentation or with incomplete or illegible documentation will be denied with no action taken by the SEHP. Any documentation submitted in any other language besides English must be accompanied with an English translation. The deadline for submitting the enrollment/change requests will not be extended.

In order to match spouse or dependent documentation to the appropriate member, the NSE HR Representative must verify prior to sending the documentation to the SEHP, that the primary member's name, employee ID, and the Non State Employer's group number is clearly written on top of each document.

A. Social Security and Individual Taxpayer Identification Numbers

According to Section 111 of the Federal Medicare, Medicaid, and SCHIP Extension Act of 2007 (the "Act"), group health plans are required to report eligibility information to the Centers for Medicare and Medicaid Services (CMS) for purposes of coordination of benefits. To satisfy the mandate, the SEHP is required to obtain valid Social Security Numbers (SSNs), Medicare Health Insurance Claim Number (HICN) or Individual Taxpayer Identification Number (ITIN) for non-resident alien individuals and their eligible dependents. Dependents include a spouse and other family members eligible to be covered by health plan benefits.

A HICN is the number assigned by the Social Security Administration to an individual identifying him/her as a Medicare beneficiary. This number is shown on the beneficiary's insurance card and is used in processing Medicare claims for that beneficiary. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services, and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performance of these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act Privacy Rule. The SSN is used as the basis for the Medicare HICN. While the HICN is required to identify a Medicare beneficiary, if the HICN is not available some beneficiaries may also be identified by the SSN. Please note that CMS has a longstanding practice of requesting HICNs or SSNs for coordination of benefit purposes.

Individual Taxpayer Identification number (ITIN): A non-resident alien individual engaged or considered to be engaged in a trade or business in the United States during the year is required to file a federal tax return each year. As a result, they must apply for an ITIN. These numbers are unique identifiers similar to SSNs and have the first 3 digits in the range of 900-999.

In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on the collection of HICN, SSN or

ITIN numbers as applicable. The SEHP requires valid SSNs or ITINs for all eligible members to participate in the SEHP to ensure the Plan is in compliance with the Act.

There are a few instances in which the SEHP will allow "temporary" SSNs to be used to set up members in the SEHP until a valid SSN or ITIN can be obtained by the primary member and updated in KEEP by the NSE Human Resources Representative.

1. Newborn children—a temporary SSN of 777-77-7777 may be assigned for a newborn until the valid SSN is obtained. Generally, SSN are assigned and issued within 14 days of application for the SSN. The valid SSN must be updated in KEEP by the NSE Human Resources Representative within **41 days** of the child's date of birth.
2. Non-resident alien individuals or their eligible dependents—a temporary SSN of 888-11-1111 may be assigned to a non-resident alien or their eligible dependents until a valid ITIN is obtained and sent to SEHP Membership Services. The valid ITIN must be provided to SEHP Membership Services within the **first 30 days of enrollment** in the SEHP. If an ITIN cannot be provided within this time frame, an online Communication form must be submitted to SEHP Membership Services providing the reason the ITIN is not available. The request will be reviewed and a determination will be made on each individual case submitted.

If the SSN or ITIN is not provided and updated in KEEP within these time periods, the dependent may be removed from the SEHP. A copy of the SSN or ITIN card can be provided as documentation.

NOTE: Valid SSNs, ITINs will be required during annual Open Enrollment for any newly added dependents. If the information is not provided during Open Enrollment the dependents will not be added to the SEHP in the following plan year. If an ITIN cannot be provided by the annual Open Enrollment deadline, an online Communication form must be submitted to SEHP Membership Services providing the reason the ITIN is not available. The request will be reviewed and a determination will be made on each individual case submitted.

B. Appropriate Supporting Documentation

The following items are appropriate supporting documentation required to be submitted to the SEHP, **in English and legible** with the Enrollment or Change Form when adding or removing other eligible individuals:

1. Marriage License (for proof of spouse and stepchild eligibility)
2. Birth certificate or hospital birth announcement for newborns including full name of the parent(s). **(Birth registration cards are not acceptable proof for newborns)**
3. Petition for adoption or placement agreement for dependent child
4. Legal custody or guardianship document issued by the court
5. Court order for dependents who are not natural or adopted children of the primary member
6. Certificate of birth and Dependent Grandchild Affidavit for children born to a covered dependent (grandchild) (see **Appendix K**)
7. An Application for Coverage of Permanent and Totally Disabled Dependent Child affidavit for covered dependent children aged 26 or older (see **Appendix L**).
8. Copies of the current year's filed Federal tax return (for proof of spouse eligibility only.) **Please note all income information may be whited out prior to submission to SEHP Membership Services.** The pages needed from the current

year's filed Federal tax return depends on which Tax form was filed:

- Form 1040—pages 1 & 2 containing the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
- Form 1040A—pages 1 & 2 containing the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
- Form 8879 (IRS *e-file*)—containing the date filed, the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.

9. Divorce decree (Only the first and last page of the court document are needed, but those pages must include the date stamp by the court and the signature of the judge)

10. A copy of a military ID and privilege card with the expiration date is acceptable as proof of Tricare coverage and to document the end of Tricare coverage.

11. For dependent loss of other group health coverage, a letter or certificate of other creditable coverage, listing the name of the member and all dependents that were covered under a previous employer's insurance is required. The letter or certificate must identify the previous employer, and list the date in which coverage ended.

C. Newborns or Adoptions

Adding a Newborn to Your SEHP Coverage for coverage tier 1 (Employee Only) or tier 2 (Employee + Spouse)

To add a newborn dependent to coverage, the primary member **must** contact their NSE HR Representative to request the addition of the dependent to coverage within 31 days from the date of birth. Appropriate dependent documentation and a valid SSN or ITIN are also required and should be sent at the same time as the request to add. The NSE HR Representative must submit the request via KEEP to SEHP Membership Services within 31 days of the date of birth. For grandchildren, a copy of the birth certificate and a completed Dependent Grandchild Affidavit (**see Appendix K**) must be submitted with the request to add the dependent grandchild. If the online request, valid SSN/ITIN and appropriate supporting dependent documentation is not received within the above time frame, the dependent will not be added for coverage.

- If the primary member already has spouse coverage, the newly eligible dependent will have medical claims processed for only the first 31 days from the date of birth. Medical claims processing for the newborn ends on the 32nd day. If the child is successfully added within the first 31 days of their birth, medical claims processing will continue and a coverage level change to Employee and Family and an appropriate premium change will occur the first of the month following the date of birth of the newborn.
- If the primary member has single coverage, the newly eligible dependent will have medical claims processed for only the first 31 days from the date of birth. Medical claims processing for the newborn ends on the 32nd day. If the child is successfully added within the first 31 days of their birth, medical claims processing will continue and an appropriate change in coverage level and premium change will occur the first of the month following the date of birth of the newborn.

Adding a Newborn to Your SEHP Coverage for coverage tier 3 (Employee + Children) or tier 4 (Employee + Family)

Effective October 1, 2013, if the primary member already has children or family coverage, the newly eligible dependent will have medical claims processed continuously beyond the first 31 days from the date of birth however the child is not permanently added to the primary member's SEHP coverage. Members are still required to properly notify the SEHP of the birth of the newborn, provide a valid SSN/ITIN and appropriate dependent documentation. If the SSN/ITIN and appropriate supporting dependent documentation is not received, claims processing for the dependent will end and the newborn will not be permanently added to their SEHP coverage.

NOTE: Regarding a newborn child of a dependent child (grandchild); the grandchild will have medical claims processed for the first 5 days from the date of birth. Medical claims processing for the grandchild will end on the 6th day unless an online change request and Dependent Grandchild Affidavit (see Appendix L) requesting to add the dependent grandchild to coverage (along with appropriate supporting dependent documentation) is received within 31 days from the date of birth

In the case of adoption, the dependent must be added to coverage within 31 days of the date that the petition for adoption or placement notice is filed or the date of adoption placement. A copy of the petition for adoption or placement notice must be submitted online along with the request to add the child to SEHP Membership Services within 31 days of the date that the petition for adoption or placement notice is filed or the date of adoption placement.

If the adoption is being handled through an adoption agency, they may require an adjustment period in the primary member's home prior to filing the petition for adoption. In this case, a copy of the adoption agency's placement letter which must include the date of placement as well as the length of the adjustment period must be submitted along with the online request.

When the adjustment period is over and the petition for adoption has been filed with the court, the primary member must submit a copy of the petition for adoption in order to continue coverage for the dependent. If the dependent is removed from the primary member's home, or the petition for adoption is not filed, an online Change request must be submitted to remove the dependent from coverage.

The NSE HR Representative should contact SEHP Membership Services for guidance if the dependent is being adopted and a petition for adoption is never filed in a U.S. court (which is sometimes the case with foreign adoptions).

D. Effective Date of Coverage

If the date of the filing for petition for adoption or placement in the home is within 31 days of the birth of the child, the coverage effective date is the date of birth provided the SEHP Membership Services receives documentation within 31 days of the birth of the child. If the filing placement is not within 31 days of the date of birth of the child, the effective date of coverage is the date of the filing date of the petition for adoption **or** the date of placement, whichever the case may be. The effective date of coverage cannot be earlier than the child's placement or arrival in the primary member's home within the United States.

If adding a newly eligible newborn or adopted dependent to coverage, other eligible dependents may also be added to coverage. The effective date of coverage for the newborn or adopted dependents will be the date of birth if an online request is completed and submitted within 31 days of the applicable child's birth. The effective date of

coverage for other eligible dependents, such as spouse and/or other children or stepchildren of the primary member, will be the first day of the month following the birth, date of placement for adoption or date of petition for adoption.

E. Change in Employee Contribution

The change in coverage will be reflected in the employee's contribution beginning the first of the month following the date of birth, date of petition for adoption or date of the placement agreement. If the date of birth, date of petition for adoption, or date of the placement agreement occurs on the first day of the month, the change in employee contribution shall not take place until the first of the following month.

F. New Legal Custody/Guardianship Dependents (for dependents who are not natural or adopted children of the primary member)

If the primary member is adding a newly eligible legal custody/guardianship dependent to coverage, the primary member must contact their NSE HR Representative to request the addition of the dependent to coverage within 31 days of the date that the court issues a legal custody agreement. The NSE HR Representative must submit the request via KEEP to SEHP Membership Services within 31 days that the court issues a legal custody agreement. A copy of the court order or legal custody agreement must be submitted along with the request.

The effective date of coverage will be the first day of the month following the date of legal custody or guardianship. If the date of legal custody or guardianship occurs on the first day of a month, the coverage effective date will be the first day of the month.

Employee contributions will be due according to the dependent coverage effective date.

G. New Spouse or Stepchildren Due to Marriage

If the primary member wants to add a new spouse and/or stepchild(ren) to coverage due to marriage, the primary member must contact their NSE HR Representative to request the spouse and/or dependents to coverage within 31 days of the event (marriage). The NSE HR Representative must submit the request along with appropriate supporting documentation via KEEP to SEHP Membership Services within 31 days of the event.

The effective date of coverage will be the first day of the month following the date of marriage. If the marriage occurs on the first day of the month, the coverage effective date will be the first day of that month.

If adding a newly eligible spouse or stepchild(ren) to coverage, other eligible dependents may also be added to coverage, such as other children of the primary member. The effective date of coverage for these dependents will be the first day of the month following the date of marriage. Employee contributions will be due according to the dependent coverage effective date

If the employee has previously waived coverage, and acquires a newly eligible spouse or dependent, (marriage, birth, adoption, etc.) the employee must contact their NSE HR Representative to request the spouse and/or dependents to coverage within 31 days of the event. The NSE HR Representative must submit the request along with appropriate supporting documentation via KEEP to SEHP Membership Services within 31 days of the event. Coverage for the employee and newly eligible spouse and dependent(s) will be effective the first of the month following the date of the qualifying event. In the case of a newborn, coverage for the newborn will be the date of birth, but coverage for the employee will be the first of the month **preceding** the newborn's date of birth. Any spouse or other dependents added during this qualifying event will be effective the first of the month **following** the date of birth of the newborn.

IV. ADDITIONAL INFORMATION

A. Children of divorced parents

A primary member may cover their dependent children:

- Who are under the age 26, or
- Who have a permanent and total disability and have continuously maintained group coverage as an eligible dependent of the primary member before reaching the limiting age to be covered under the plan. The child must be chiefly dependent on the primary member for support (receive more than 50% of his or her support from the primary member).

B. Ex-Spouse

When the primary member is divorced from their lawful wife or husband, the ex-spouse and subsequent stepchildren are no longer eligible to participate in the SEHP except as allowed under COBRA continuation coverage.

C. Spouses residing out-of-country

A spouse (of an eligible primary member) who is not a U.S. citizen and resides in another country, is eligible for SEHP coverage when the primary member is newly eligible, when newly married to the primary member, when they move and maintain a permanent United States residence, including having an active U.S. Social Security or Tax Identification Number from the U.S. government or at Open Enrollment. The primary member will be allowed to add the spouse to coverage provided the request is made by the primary member within 31 days of any of these events. If the spouse later returns to another country, coverage may not be dropped for the spouse until the next Open Enrollment period (unless enrolled on an after-tax basis). Documentation is required to support the primary member's request.

D. Dependents residing out-of-country

A dependent child(ren) (of an eligible primary member) who is not a U.S. citizen and resides in another country, is eligible for SEHP coverage when the primary member is newly eligible, when they move and maintain a permanent United States residence, including having an active U.S. Social Security or Tax Identification Number from the U.S. government or at Open Enrollment. The primary member will be allowed to add the dependent child(ren) to coverage provided the request is made by the primary member within 31 days of any of these events. If the child(ren) later returns to another country, coverage may not be dropped for the child(ren) until the next Open Enrollment period (unless enrolled on an after-tax basis). Documentation is required to support the primary member's request.

E. Adopted child

A primary member may cover an adopted child if the petition for adoption has been filed with the court, if the primary member has a placement agreement for adoption, or if the primary member has been granted legal custody of the child. Supporting documentation must be provided in English and must be submitted to SEHP Membership Services. Adopted children who are not U.S. citizens and who reside in another country are not eligible for coverage until they move and maintain a permanent United States residence. If the child(ren) later returns to another country, coverage may not be dropped for the child(ren) until the next Open Enrollment period (unless enrolled on an after-tax basis).

F. Court Ordered Dependents

When the SEHP receives a National Medical Support Notice that orders the employer of a primary member to provide health insurance coverage for a dependent child, that child

will be automatically enrolled onto the primary member's coverage. Notice of the court order will be sent to the primary member, the NSE HR Representative, the custodial parent(s), the carriers, and the court serving the notice. A court-ordered dependent can only be removed from coverage if one of the following occurs:1) the issuing court sends the SEHP a rescinding order that voids the initial support notice; 2) the child is no longer an eligible dependent on the SEHP; or 3) the primary member provides proof of other creditable coverage for the child. The child cannot be removed at Open Enrollment.

A court ordered dependent will be added the first of the month following receipt of the National Medical Support Notice by the SEHP. If the court order is rescinded, the child can be removed from the primary member's coverage, pending the SEHP receives an online change request to remove the child within 30 days of notice. The effective date of the removal would be the first of the month following the receipt and approval of the online change request by the SEHP.

G. Special Notes

- The State of Kansas and the SEHP reserve the right to request documentation to support proof of dependency and/or residency. When enrolling other eligible individuals for coverage with the SEHP, the primary member must certify:
  1. The spouse and/or dependent(s) meet the requirements for other eligible individuals for the year in which the spouse and/or dependent(s) are being enrolled.
  2. The primary member must also provide appropriate supporting documentation for their spouse and each dependent (such as the birth certificate, adoption papers, marriage license, etc.) See additional information above in **Section III A.**
- In order to match other eligible individual documentation to the appropriate primary member, the NSE HR Representative must verify prior to sending the documentation to SEHP Membership Services, that the primary member's name, employee ID, and the NSE group number is clearly written on top of each document
- Requests that are submitted without documentation or with incomplete documentation will be denied with no action taken by the SEHP. The deadline for submitting the enrollment/change forms will not be extended.

NOTE: Any attempt to enroll other eligible individuals who do not meet the SEHP requirements will be considered fraud and will be subject to penalties as prescribed by law.

CHAPTER 5 - HEALTHQUEST PROGRAM

This section applies to all active members who are enrolled in SEHP options Plan A, B or C.

HealthQuest is the health and wellness program for employees and members of the State Employee Health plan. Services are available to eligible members at no additional cost. There are two main program areas:

A. Wellness Offerings

- Nurse Line
- Biometric Screenings
- Health Coaching
- Condition Management
- Tobacco Cessation
- Rewards Program, and more!

Who is Eligible to use the Wellness Services?

- Benefits eligible Non State employees who are enrolled in the State Employee Health Plan or who have waived coverage in the plan
- Retirees, spouses and dependents 18 years or older who are enrolled in the medical portion of the State Employee Health Plan

B. Employee Assistance Program

- Confidential Short-Term Personal Counseling
- Legal Advice and Discounts
- Personal Money Management Assistance and Information
- Eldercare/Childcare Information and Referral
- Life Coaching

Who Is Eligible to Use the Employee Assistance Program (EAP)?

- All active, benefits-eligible employees of our Non State Employer Groups, their dependents and other family members living in the same household
- Direct Bill Retirees and COBRA participants are not eligible to participate

NOTE: Benefits-eligible employees who have been laid off/terminated are eligible to use the EAP for six months after layoff.

The toll-free telephone number for HealthQuest programs is 1-888-275-1205. For more information on HealthQuest Programs, please visit **www.kdheks.gov/hcf/healthquest**

HEALTHQUEST REWARDS PROGRAM

Employees enrolling in the medical portion of the State Employee Health Plan have an opportunity to earn a premium incentive discount on their health insurance premium through the HealthQuest Rewards Program. The HealthQuest Program year (also known as the earning period for the incentive) runs from August 1st through July 31st. Further information on the premium incentive program can be found in **Chapter 7-Cost of Coverage**. Because the requirements to earn a discount may change from year to year, please refer to the HealthQuest website for full details on the current Rewards Program, including a flyer for new health plan members: **www.kdheks.gov/hcf/healthquest/rewards.html**

Employees will need to set up a HealthQuest account on the wellness portal to begin earning credits toward their discount. As a general guideline, new members should have access to the HealthQuest programs within two weeks of submitting their health insurance paperwork (they do not have to wait until their coverage begins). Instructions for registering an account are provided at:

www.kdheks.gov/hcf/healthquest/download/How_to_Register_an_Account.pdf

TOOLS AND RESOURCES FOR HR MANAGERS AND SUPERVISORS:

A. Program Materials

Go to **www.kdheks.gov/hcf/healthquest/documents.htm** to download materials for your worksite such as:

- Brochures
- Posters/Flyers
- How To Guides for the Wellness Portal

B. Critical Incident/Stress and Grief Counseling Sessions

Human Resource Managers can contact the EAP vendor, Alternatives EAP, at 816-753-8283 for information about Critical Incident/Grief Counseling Sessions for employee groups experiencing trauma or major loss. A counselor will come to the worksite and present to groups or talk with people one-on-one to help them process the grief or trauma. *Handling Grief and Loss: Guidance for Employees and Managers*, an 11-page handout, is available at **www.kdheks.gov/hcf/healthquest/eap/csid.html**

C. Mandatory Referral - Fitness For Duty

Occasionally circumstances arise when we would question the emotional stability of an employee or their ability to perform safely. We may also be concerned about the safety of other employees or the individuals we serve. The Fit For Duty program is not designed to address chronic disciplinary or performance problems, but behavioral changes in employees that may pose a potential threat to self or others in the work place. If assistance is needed in dealing with chronic disciplinary or performance problems or you would like to discuss the Fit For Duty option please consult the Division of Personnel Services at 785-296-4274.

More information is available at **www.kdheks.gov/hcf/healthquest/eap/ffd.html**

D. Conflict Resolution Program

This service partners a Non State Employer Group with the HealthQuest Employee Assistance Program (EAP) that would enable employees the opportunity to resolve conflicts at work. The objective of the program is to provide a mechanism to aid the participants in: identifying the issues, reducing misunderstandings, clarifying priorities, exploring areas of commonality, and assisting the participants in resolving the conflict to improve job performance and their differences at work. The Conflict Resolution Program offers two avenues for employees to use the service. The first is confidential and voluntary. The second is a formal request from the Non State Employer.

More information is available at **www.kdheks.gov/hcf/healthquest/conflictresolution.html**

CHAPTER 6 - EMPLOYEE MEDICARE ELIGIBILITY

Congress has created a framework in the Medicare statutes and the Internal Revenue Code that imposes responsibility on an employer for its plan's actions in certain circumstances. The Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. 1395y(b)) state that Medicare may seek to recover a mistaken primary payment from "any entity which is required or responsible" to pay for medical services under a primary plan. Accordingly, Medicare may seek recovery from the employer.

The MSP provisions generally require group health plans to make payments primary to Medicare for: (1) individuals entitled to Medicare on the basis of age or disability if the individual has coverage under the group health plan on the basis of the individual's own or a family member's current employment status; and (2) individuals who are or could be entitled to Medicare on the basis of end stage renal disease for a 30 month coordination period if the individual is covered under a group health plan, as defined in the Internal Revenue Code, on any basis. Taken together, the MSP provisions and the definition of group health plan establish that employers have, or at least share, responsibility for the group health plan's compliance with the MSP rules.

For this reason it is very important to ensure that our members, their spouses and dependents are accurately enrolled in the Health Plan. The SEHP must be aware of any Medicare eligibility and entitlement so that the SEHP can communicate this information to our carriers. If a Non State Employer receives a demand letter from a Medicare secondary payer recovery contractor, forward the letter and any attached documentation to SEHP Membership Services.

I. EMPLOYEES AND SPOUSES WHO ARE APPROACHING AGE 65

When an active employee or covered spouse turns age 65, they must complete a TEFRA (Tax Equity & Fiscal Responsibility Act of 1982) Health Care Selection Form (see **Appendix D**). On the TEFRA form, the employee or covered spouse must select Medicare or the SEHP as primary carrier. SEHP Membership Services will send a list to each Non State Employer of impacted employees or covered spouses approximately 90 days prior to the employee's or spouse's 65th birthday advising them that a TEFRA Form must be completed by the employee or spouse. The NSE HR Representative should contact the employee and/or covered spouse and obtain a signed TEFRA form from them. The TEFRA Form must be completed 45 days prior to the 65th birthday of the employee or covered spouse and received by SEHP Membership Services within 10 days of completion. If the employee or spouse has a Medicare card, a copy should be attached to the TEFRA form.

A. If the employee / spouse selects the State Employee Health Plan as primary:

The employee / spouse will continue the same coverage at the same rate with the SEHP. Claims for the primary member and spouse will be processed with the SEHP as primary.

B. If the employee selects Medicare as primary:

1. If Medicare is selected as primary, the employee will be removed from the SEHP medical and dental benefits effective the 1st of the month in which they become eligible for Medicare. If the employee turns age 65 on the first day of the month, Medicare eligibility will begin the first day of the previous month, the SEHP benefits will terminate on that day. Coverage for all dependents will also be terminated as of the same date. The TEFRA form will be used to terminate the medical and dental benefits. Vision coverage is not affected by Medicare, so if the member and any dependents are enrolled in the vision coverage, the vision coverage will not be terminated.

If the spouse selects Medicare as primary, the spouse will be removed from the SEHP benefits effective the 1st of the month in which they become eligible for Medicare. If the employee turns age 65 on the first day of the month, Medicare eligibility will begin the first day of the previous month. The SEHP benefits will terminate on that day. The TEFRA form will be used to terminate the medical and dental benefits. Vision coverage is not affected by Medicare, so if the spouse is enrolled in the vision coverage, that coverage will not be terminated.

2. The covered spouse and/or dependent children can continue coverage on COBRA for up to 36 months or until entitled to Medicare, whichever occurs first.

II. EMPLOYEES, SPOUSES AND DEPENDENTS WITH MEDICARE DUE TO DISABILITY

New hires should be asked if they or any dependents that they plan to cover under the SEHP are Medicare eligible. Medicare information should be should be entered on the Medicare tab in KEEP and a copy of the Medicare card should be submitted to SEHP Membership Services at that time.

Active employees, spouses and/or dependents that become newly eligible for Medicare due to disability during the plan year have the option to continue to participate in the SEHP or to have Medicare coverage as primary. A request should be submitted in KEEP by the NSE Human Resource Representative indicating that the member is now eligible for Medicare. If they wish to remain on the SEHP, the NSE HR Representative must enter the Medicare information for the member on the Medicare tab and submit a copy of the Medicare card to SEHP Membership Services. Those members who want Medicare as primary must be submitted as a termination via KEEP to SEHP Membership Services. The member will be removed effective the first day of the month that Medicare becomes effective. The NSE HR Representative must enter the Medicare information for the member on the Medicare tab and submit a copy of the Medicare card to SEHP Membership Services.

Federal law mandates Medicare to be the secondary payer of claims for active employees or their dependents that choose to remain covered by the SEHP, even though they are disabled and entitled to Medicare benefits.

III. EMPLOYEES, SPOUSES AND DEPENDENTS WITH MEDICARE DUE TO END STAGE RENAL DISEASE (ESRD)

Persons with ESRD may be eligible for Medicare primary coverage for a period of time as determined by Federal guidelines. The NSE HR Representative must enter the Medicare information on the Medicare tab in KEEP. The ESRD Questionnaire (Appendix J) should be completed and forwarded to SEHP Membership Services immediately when ESRD is diagnosed for a covered member, spouse or dependent, so that appropriate Medicare eligibility information can be forwarded to the medical plans and members.

When Medicare is primary for a covered person with ESRD, there is no change in active employee rates, coverage eligibility or benefits. However, medical claims are processed with Medicare coverage as primary and SEHP coverage as secondary.

CHAPTER 7 - COST OF COVERAGE

Employee and Non State Employer Group contributions for the SEHP are subject to change each Plan Year. SEHP coverage is monthly and rates are based on monthly periods. Coverage termination will be effective the first day of the month following termination of employment.

I. EMPLOYEE RATES

SEHP employee rates are based on the following criteria:

A. Full-time or part-time employment status of the employee's position (see Chapter 3, Section VI)

1. For full-time employees, the Non State Employer is required to contribute approximately 95% of the cost of single coverage and approximately 55% of the additional cost for dependent coverage. The Non State Employer may choose to pay more than the required amount for employee and dependent coverage

2. For part-time employees, the Non State Employer is required to contribute approximately 75% of the amount contributed for full-time employees.

Salary tiers must be reported for all employees during the request for coverage and salary tier changes must be reported to the SEHP each year in November. If the employer is paying 100% of the single employee premium, the salary tiers do not apply to the premiums however; the tiers must still be reported to the SEHP and updated annually.

B. Annual salary range of the employee's position **(see Chapter 3, Section VII)**.

Salary Range 1: annual salary less than $28,000

Salary Range 2: annual salary of $28,000 to $48,000

Salary Range 3: annual salary of more than $48,000

C. Health (medical/prescription drug, dental and vision) plans selected

D. HealthQuest Rewards Program

E. Coverage level selected

II. HEALTHQUEST REWARDS PROGRAM INCENTIVE

New Primary Member Participation in the HealthQuest Rewards Program Incentive

New primary members (employees) with benefits effective dates of March 1, 2013, or later, will pay the health plan premium rate until they have earned the $40 per month HealthQuest Rewards premium incentive discount. To earn the premium incentive discount, the primary member needs to complete the health assessment questionnaire (worth 10 credits) plus earn 20 additional credits (for a total of 30 credits).

NOTE: Anyone hired on or after January 3, 2013, will have a benefits effective date on or after March 1, 2013, and will fall under the new primary member policy for the HealthQuest Rewards Program.

The following scenarios would also fall under the new primary member policy if their benefits effective date is March 1, 2013, or later:

A. Employees who previously waived coverage but decide to enroll in the health plan due to a qualifying event

B. Employees returning from military leave who re-enroll into the health plan

C. Employees who move to a different state agency with a break in coverage and re-enroll into the health plan (if there is no break in coverage, they are not subject to the new primary member guidelines)

The SEHP does a weekly mailing to households of all new primary members that advises them of the Incentive Rewards Program opportunity. It is recommended that Agency HR staff provide information to employees during new employee orientation or when going over health benefits enrollment, etc.

D. New Non State groups coming onto the health plan

The recommended handouts are:

1. Rewards Program handout for New Members
2. Instructions for setting up their HealthQuest account
3. Employee Assistance Program handout

These 3 items (and more) can be found at:
www.kdheks.gov/hcf/healthquest/documents.htm Additional Info:

- By completing the HealthQuest Rewards requirements, new primary members will be eligible to receive the premium incentive discount for the current plan year and have those same credits apply to the current earning period. Once the requirements are met, the SEHP will be notified so that the discount can be applied to the next available pay cycle.
- New primary members have twelve (12) months from their benefits effective date to complete the requirements and have the Reward apply to multiple plan years (see examples below). After the first twelve (12) months, new primary members will follow the same qualifying requirements as any other primary member and have until July 31 each year to qualify for the following year.
- In general, new primary members can access the wellness portal at **www.KansasHealthQuest.com** to establish an account and start earning credits within two weeks after their health insurance paperwork is submitted to the SEHP.
- The earning period for all primary members to qualify the next year's premium incentive discount is August 1 through July 31 of each year. It is important that new primary members understand that the wellness portal is reset every August 1 to zero credits for the start of the new earning period for all primary members. Different earning periods are not able to be set on the wellness portal for new primary members so all accounts are reset on August 1. New primary members may want to complete the requirements either prior to August 1 or wait until after August 1 to start earning credits.
- Whatever earning period HealthQuest is in at the time the new primary member completes the requirements, that is the discount they are qualifying for. As a new member, they also get the discount for everything leading up to that. See chart for details

Completion Date of Rewards Program Requirements	New Primary Member Qualifies for Plan Year 2013 Discount	New Primary Member Qualifies for Plan Year 2014 Discount	New Primary Member Qualifies for Plan Year 2015 Discount
3/1/13 – 7/31/13	X	X	
8/1/13 – 12/31/13	X	X	X
1/1/14 – 7/31/14		X	X

Helpful Examples:

A. Employee A has a benefits effective date of March 1, 2013, and completes the requirements in May 2013. Employee A qualifies to receive the discount for the rest of plan year 2013 and has qualified for plan year 2014. Employee A will start over on August 1, 2013, earning credits toward the 2015 discount.

B. Employee B has a benefits effective date of April 1, 2013, and earns a few credits but does not meet the requirements. The new program year begins on August 1, 2013, resetting all account back to zero credits. Employee B earns the necessary credits and completes the requirements in October 2013. Employee B qualifies to receive the discount for the rest of plan year 2013 and has qualified for both 2014 and 2015.

C. Employee C has a benefits effective date of June 1, 2013, but decides to wait until the new earning period begins in August to participate. Employee C completes the requirements in September 2013 to receive the discount for the rest of plan year 2013 and has qualified for both 2014 and 2015.

D. Employee D has a qualifying event in November 2013 and enrolls in the health plan with a benefits effective date of December 1, 2013. Employee D completes the requirements in March 2014 to receive the discount for the rest of plan year 2014 and has qualified for 2015.

More information on the Rewards Program can be found at

www.kdheks.gov/hcf/healthquest/rewards.html

CHAPTER 8 - OPEN ENROLLMENT

I. ANNUAL OPEN ENROLLMENT PERIOD

Open Enrollment for active primary members' health benefits occurs annually during the month of October. A primary member who enrolls during the Open Enrollment period will have coverage effective the first day of the new Plan Year as outlined in the current Health Plan Summary/Open Enrollment booklet.

Non State Employer Group eligible members must complete the Open Enrollment process each plan year to change medical plans, add or drop coverage, add or drop a spouse or dependent from coverage, or change pre-tax payment status (if offered by the Non State Employer Group).

Eligible employees who are on Leave Without Pay or Family Medical Leave Act must be sent Open Enrollment materials by the Non State Employer HR Representative to be completed and submitted during the Open Enrollment period.

Open Enrollment will be completed via the Internet using the online Open Enrollment segment of the Kansas employee eligibility portal (KEEP). Information concerning online enrollment is published prior to the annual Open Enrollment period. Members can also provide change of address and other demographic changes in KEEP. This ensures that current addresses and other contact information are maintained by the SEHP so that employees can receive health plan information timely.

Members can change their Health Savings Account (HSA) contribution amount if enrolled in the Qualified High Deductible Health Plan. This does not have to be reported to the SEHP, but should fall within the IRS minimum and maximum contribution amounts.

NSE HR Representatives will have access to online reports of Open Enrollment activity so they can monitor and help ensure employees complete their Open Enrollment.

Special Notes:

- Each employee will be required to have their own unique and valid email address (either work or personal) in order to access KEEP.
- A valid SSN or ITIN is required to be submitted to SEHP Membership Services by the established deadline for each newly added spouse or dependent during Open Enrollment. If a valid SSN or ITIN is not received by the deadline, the spouse or dependent will not be added to the primary member's coverage in the new Plan Year. See **Chapter 4, Section III A** for additional information.
- Acceptable dependent documentation is required to be submitted to SEHP Membership Services by the established deadline for each newly added spouse or dependent during Open Enrollment. If acceptable documentation is not received by the deadline, the spouse or dependent will not be added to the primary member's coverage in the new Plan Year. See **Chapter 4, Section III B** for additional information.
- A primary member cannot remove a spouse from coverage during the Open Enrollment period in anticipation of a divorce. The spouse can be removed from coverage once the divorce is final. A copy of the divorce decree must be submitted to SEHP Membership Services within 31 days of the final divorce decree.

In order to match spouse or dependent documentation to the appropriate member, the NSE HR Representative must verify prior to sending the documentation to the

SEHP, that the primary member's name, employee ID, and the Non State Employer's group number is clearly written on top of each document.

II. PRE-EXISTING CONDITIONS

The SEHP does not apply an additional waiting period for pre-existing conditions for primary members, their spouses and their dependents that enroll in health coverage during the Open Enrollment period. Certificates of Creditable Coverage from other medical plans are not needed for Open Enrollment.

III. NEWLY ELIGIBLE PRIMARY MEMBERS

Newly eligible primary members who have completed their 30 day waiting period may enroll during their initial enrollment period for an effective date of coverage for the current Plan Year. In addition, during the month of October, the primary member may complete Open Enrollment online and elect different coverage to be effective for the new Plan Year. Please note, a member must complete their initial enrollment before they may complete any changes for Open Enrollment.

IV. OPEN ENROLLMENT CONFIRMATION STATEMENTS

Members who complete their Open Enrollment online via KEEP will automatically receive a confirmation statement upon saving and submitting their enrollment elections. NSE HR Representatives will be able to run a report at the end of open enrollment to see what their employees have elected for the next plan year.

V. IDENTIFICATION CARDS

Identification (ID) cards will be sent to new members and members making coverage level changes. If a member is expecting but does not receive a new ID card by the end of December, the member should contact the applicable carrier to request that new ID cards be sent. Telephone numbers for the carriers are listed in the front of the Health Plan Open Enrollment booklet and can be found on the SEHP web site at **www.kdheks.gov/hcf/sehp/VendorProviderDirectories.htm**

CHAPTER 9 - HEALTH PLAN MATERIALS

I. BENEFIT DESCRIPTIONS / CERTIFICATES / BOOKLETS

SEHP carriers will mail Benefit Descriptions for self-insured plans and Certificates of Coverage for fully insured plans to all enrolled members directly to their last known home address on file with the SEHP. Certificate books will be sent after SEHP Membership Services has processed the primary member's enrollment and the carrier has processed the primary member's information.

The Certificate of Coverage and Benefit Description are also available on the website at **www.kdheks.gov/hcf/sehp/BenefitDescriptions.htm**

II. IDENTIFICATION CARDS

Separate Identification (ID) Cards are issued by the appropriate carrier for medical, prescription drug and dental coverage. Members electing vision coverage will also receive an ID card. Dental and vision ID cards may also be obtained by accessing the carrier's web site. Members should allow 2 to 3 weeks after the date their enrollment request is approved by SEHP Membership Services for coverage to be established with the applicable carrier(s).

SEHP carriers will mail Identification Cards directly to the member's last known home address on file with the SEHP. If a member has not received an ID card after 3 weeks, the member should contact their carrier and request that a new card be sent. Members should carry their ID cards at all times and present the appropriate ID card whenever covered services or benefits are needed.

For additional information concerning identification cards and Open Enrollment, refer to **Chapter 8, Section V**.

III. PROVIDER LISTINGS

The most current provider lists are available on each carrier's website. This information can be accessed through the SEHP website at:
www.kdheks.gov/hcf/sehp/VendorProviderDirectories.htm

Members may call their carriers using a local or toll free number (depending on the member's location) as listed on the ID card or on the SEHP web site. Addresses for medical carriers are also listed in **Appendix O**.

REMINDER: NSE HR Representatives must ensure that current valid employee addresses are on file with SEHP Membership Services. It is important that current addresses are maintained by the NSE HR Representative in KEEP so that employees can receive health plan information timely.

CHAPTER 10 - ENROLLMENT REQUESTS AND INSTRUCTIONS

I. ENROLLMENT REQUESTS

The Enrollment Form (**see Appendix B**) can be used as a tool to collect information for application for new coverage and as an authorization by the eligible employee for the NSE to deduct the employee's contributions from the employee's paycheck for the coverage requested. The Enrollment form can be retained by the NSE HR Representative for their records after the NSE HR Representative enters the Enrollment request in KEEP. No paper enrollment forms will be accepted by the SEHP.

All items contained on the Enrollment form are required to be entered into KEEP to set up status records and request an enrollment for an eligible employee. The Enrollment request and any supporting documentation must be entered by the NSE HR Representative in KEEP, and the eligible employee must complete and submit their initial enrollment in KEEP to SEHP Membership Services for approval within 31 days of the qualifying event. Online enrollment requests that are submitted without supporting documentation or with incomplete supporting documentation (please see Chapter 12) will be denied by SEHP Membership Services with no action taken by the SEHP. The deadline for submitting the Enrollment request with documentation will not be extended.

For any situation that an employee is not required to meet the 30 day waiting period requirement, an explanation should be entered in the comment box on the online request by the NSE HR Representative. The employee's contribution must initially be paid on an after-tax basis when the 30 day requirement is waived. The primary member may change to the pre-tax premium option effective the first day of the month that their coverage would have become effective without the waiver. If the primary member desires to change to the pre-tax option after this time period, an explanation should be entered in the comment box on the online Change request to SEHP Membership Services. A copy of the waiver approval letter must be uploaded via the "Upload" tab in KEEP.

For example:

- Waiver of the 30 day waiting period—A copy of the approval letter from the SEHP must be uploaded in KEEP along with the online Change request.
- Employee changing from non-eligible to eligible status
- Return from leave for an employee who was on leave over the Open Enrollment period
- Employee has terminated, had health insurance and was not gone from NSE employment more than 30 days
- Employee was laid off from NSE employment and is returning to a benefits eligible position with the NSE within 365 days from the date of layoff

For all of the above events, eligibility dates, dates of return from leave, and any other appropriate event dates must be entered in the KEEP online change request.

All required documentation must contain the member's name, KS Employee ID, and NSE department ID clearly written on the item prior to being uploaded into KEEP.

SEHP Membership Services must receive the online request and the appropriate documentation within 31 days of the event. If processed, the approval will appear on the Notification Manager in KEEP. Enrollment information will then be forwarded to the appropriate carrier(s). Allow 2 to 3 weeks after the Enrollment request is received by SEHP Membership Services for coverage to be established with the applicable carrier(s).

NOTE: Employees, covered spouses and dependents must be enrolled in the same medical plan.

II. INSTRUCTIONS FOR ONLINE ENROLLMENT REQUEST

A. Before making an enrollment request online, have this information prepared to input into the KEEP system: **For HR Use Only** (to be completed by the NSE HR Representative)

- The Non State Group username and password for employer access to the KEEP website: **https://hr.hrissuite.com/console/**
- The Date of Event for the employee's qualifying event (required)
- The Employee ID number (required–if entering a new employee, one will be assigned)
- Any documentation that may be required to process the enrollment (i.e. dependent documentation)

B. Create Employee

This section includes demographic information supplied by the employee and can be found under Create Employee:

- The employee's full name (required)
- Mailing address (required)
- Contact telephone number (required)
- Social Security Number or ITIN for non-resident alien (required)
- Gender (required)
- Date of birth (required)
- Valid contact email address (required)
- Marital Status (required)

Member Information

- Date of Hire/Event (required)
- Benefit Program or salary tier range (required)

C. Dependent Information

For each primary member, spouse and covered dependent, the following information is required:

- Relationship (e.g., child, spouse, stepchild, etc.) The NSE HR Representative shall collect and upload supporting documentation for each covered spouse and dependent. The SEHP and/or the carrier may request documentation to support proof of relationship or dependency;
- Full Name – last name, first name, middle initial;
- SSNs, HICN or ITINs (for non-resident alien individuals) are required for every individual over 30 days old. If the SSN or ITIN is not received, an alternative number will be assigned by SEHP Membership Services for a period of 60 days. If a valid SSN or ITIN is not received within that time the dependent may be removed from SEHP coverage.
- Gender (required);
- Date of Birth (required) – If the primary member or spouse is age 65, a TEFRA Health Care Selection Form (see **Appendix D**) must be completed. If Medicare is selected

as primary coverage, the spouse is only eligible to enroll in the SEHP vision coverage and will not be enrolled in the SEHP medical and dental coverage. (See **Chapter 6**)

- Dependent address – The primary member must provide the dependent's address if it's different from their own.

SPECIAL NOTES:

- To be enrolled as a spouse or dependent under a primary member's coverage in the SEHP, the primary member, spouse and the dependent must be enrolled in the same medical plans.
- In order to match spouse or dependent documentation to the appropriate primary member, the NSE HR Representative must verify prior to uploading the documentation in KEEP and submitting to the SEHP, that the documentation is legible, provided in English and that the primary member's name, employee ID, and the NSE Group Number is clearly written on top of each document.
- If the dependent's address is different than the primary member's, their address must be provided in the appropriate area in KEEP.
- NSE HR personnel must ensure that current valid employee addresses are on file in the KEEP system. It's important that current addresses are maintained in the KEEP system so that employees can receive health plan information timely.

D. Medicare

If the primary member, spouse, and/or dependent are eligible for Medicare and are to be covered under the SEHP, the primary member should provide the following information for the NSE HR Representative to complete this section in KEEP. The member is also required to provide copies of all Medicare cards to be uploaded via the "Upload" tab in KEEP.

- Name – last, first, middle initial;
- Hospital (Part A – month/day/year);
- Medical (Part B – month/day/year);
- Medicare Claim Number (HICN)

E. Employee and Personnel Officer Authorization

The NSE HR Representative must authorize that they are entering all information in KEEP at the request of an employee of their NSE group and is complete and accurate to the best of their knowledge. They also ensure that appropriate supporting documentation is included, and that the employee agrees to the terms and conditions of the SEHP. They authorize the information submitted in KEEP will be used to determine eligibility for SEHP coverage. By this authorization they further understand that if any material information is omitted or incorrect, it could provide the basis to refuse or rescind coverage and refund any premiums paid as though coverage had never been in force.

F. Benefits

After inputting the employee's information, the HR Benefits Representative should request an initial enrollment period for the new member by doing the following:

- Click on the **Benefits** tab
- Click the **Edit Benefits** button
- Select **'Enrollment for New Employee (of) Newly Eligible Employee'**
- Scroll to the bottom of the screen. Read the *User Agreement and Attestation* clause.
- Check the box indicating the HR Benefits Representative has read and agreed to the

User Agreement and Attestion clause

- Click the **Continue** button
- Select **New Hire** (or any of the options that are applicable – i.e. Transfer, etc)
- Click on **Submit Request**
- Check the **Notifications** menu to ensure that the request was successfully sent

G. New Non State groups coming onto the health plan-Initial Enrollment Portal (to be completed by the employee)

Once the initial request for enrollment is submitted and approved by SEHP Membership Services, an initial online enrollment period will be set up and communicated back to the HR Representative. The HR Representative must notify the employee to complete their initial enrollment via KEEP. They must complete their online initial enrollment election within the first 31 days of their hire date.

If an employee does not access the portal to make elections within this timeframe, they will be locked out of the portal and their initial coverage will be automatically waived.

The enrollment portal for all new employees: http://employee.hrissuite.com/enroll/

G. Coverage Election (to be completed by the employee)

The employee must indicate how they want to pay for the cost of coverage. The choice indicated here directly impacts enrollment changes that can be made by the primary member as a result of a mid-year qualifying event.

They may choose:

- Before tax, or
- After tax

H. Medical Insurance Provider (to be completed by the employee)

Primary members may choose from any currently offered medical plan. Primary members may also choose to waive medical/dental/prescription drug coverage. Primary members who enroll in the Qualified High Deductible Health Plan (Plan C) must also make a contribution of at least $50.00 per month to a Health Savings Account (HSA) **(Chapter 22)**. The contribution should be handled internally via the NSE group's payroll department once the HSA bank account number is received by the member.

The primary member indicates their choice of health plans and their choice of carrier. The primary member selects one plan choice (Plan A, B, or C) and 1 medical provider.

Medical insurance provide and plan choices are:

- Blue Cross Blue Shield (Plan A, Plan B, and Plan C- Qualified High Deductible Health Plan with Health Savings Account),
- Coventry (Plan A, Plan B and Plan C - Qualified High Deductible Health Plan with Health Savings Account),
- United Healthcare (Plan A, Plan B and Plan C-Qualified High Deductible Health Plan with Health Savings Account)

NOTE: The primary member must enroll in a HSA when Plan C is selected. The amount they deduct should be reported to your payroll department. The SEHP does *NOT* require notification of those contribution amounts for our NSE groups.

NOTE: Primary members are not permitted to change Plans during the Plan Year. The only mid-year changes allowed are coverage level changes which are consistent with the qualifying event.

All primary members, spouses and dependents with medical coverage will also have the same level of prescription drug coverage. Primary members may elect one of the following coverage levels for medical and prescription drug. Prescription drug coverage through Caremark is provided for members that select a medical insurance provider and Plan. Primary members may select Medical and Prescription Drug Coverage levels by indicating their selection online in KEEP:

- Waive coverage
- Coverage for Primary member only
- Coverage for Primary member and Spouse only
- Coverage for Primary member and Child(ren) only
- Coverage for Primary member and Family (Spouse and Child(ren))

Primary member only dental coverage is automatically provided for all primary members enrolled in medical/prescription drug coverage. Employees may choose from among the following dental coverage levels by indicating their selection online in KEEP for:

- Primary member only
- Dependent Dental (Coverage for Primary member and all Dependents who are also enrolled in Medical coverage)

SPECIAL NOTES:

- Dental **ONLY** coverage is NOT available for spouses or dependents.
- Under SEHP guidelines, if the member wishes to have dependent dental, the same dependents that are enrolled in medical coverage must also be enrolled in the dental coverage and the coverage level on the dental must match the coverage level on the medical coverage. For example, a primary member who currently has Primary member/Spouse medical/dental and wants to add a dependent to their medical coverage must also enroll the same dependent in dental coverage. The coverage level would change from Member and Spouse to Member and Family The same dependents that are covered under the medical are also enrolled in the dental coverage and the coverage level on the dental must match the medical coverage level.
- Dependent dental coverage may not be dropped during the Plan Year unless dependent medical coverage is also dropped.

I. Vision Coverage Level (Optional)

Primary members may elect:

- The Basic Plan
- The Enhanced Plan
- Waive Vision Coverage

Primary members may elect a vision level different than their coverage level in a medical or dental insurance plan. **The dependent children covered in the vision plan must match/include the dependent children covered under the medical/prescription drug plan.** For example, the primary member currently has Member and Family Medical, Member only dental and wishes to have Member and Family Vision. The primary

member has 2 children covered under the medical coverage. The same 2 children that are enrolled in the medical coverage must be enrolled in the vision.

Primary members may choose from among the following coverage levels:

1. Primary Member Only
2. Primary Member and Spouse
3. Primary Member and Child(ren)
4. Primary Member and Family - with Spouse and Child(ren)

Vision coverage may be added during the Plan Year only for newly eligible employees, spouses and / or dependents. Members cannot change from Basic to Enhanced vision coverage or vice versa during the Plan Year.

Primary members may enroll in the vision plan only when first newly eligible (upon hire), or during Open Enrollment. Spouses and / or dependents may be added mid-year if a qualifying event makes the spouse or dependent newly eligible (marriage, birth of child, etc.), and only if the Primary member is currently enrolled in a vision plan. Primary members, who initially waived vision coverage and have a mid-year qualifying event acquiring a spouse or dependent, will not be allowed to enroll themselves, their spouse or dependent(s) in the vision coverage. Please see **Chapter 12** for a list of qualifying events.

Newly eligible spouses and / or dependents may be added to vision coverage only if the primary member has elected vision coverage.

CHAPTER 11 - CHANGE REQUESTS AND INSTRUCTIONS

I. CHANGE REQUESTS

The Change Form (see Appendix C) can be used as a tool to collect information for all qualifying event changes as requested and authorized by the eligible primary member. The completed Change Form can be used by the NSE HR Representative to enter the change request via the online Kansas employee eligibility portal (KEEP) system along with the appropriate documentation. The change form can be retained by the NSE HR Representative for their records after the NSE HR Representative enters the change request in KEEP. No paper change forms will be accepted by the SEHP.

All items contained on the change form are required to be entered into KEEP to update status records and request a change for an eligible employee. The change request and supporting documentation must be entered by the NSE HR Representative in KEEP and submitted to SEHP Membership Services for approval within 31 days of the qualifying event. Online change requests that are submitted without supporting documentation or with incomplete supporting documentation (please see Chapter 12) will be denied by SEHP Membership Services with no action taken by the SEHP. The deadline for submitting the change request with documentation will not be extended.

II. CHANGE REQUEST INSTRUCTIONS

Change requests are required in the following situations:

- Mid-year enrollment changes (see **Chapter 12**)
- Name changes
- Address changes
- Personal demographic/data corrections (such as date of birth, SSN, etc.)
- Transfers between Non State Employer Groups. Transfers of positions within the same NSE group are not required,
- Cancellation of primary member's coverage due to non-payment of employee premiums while on active status
- Change from an eligible to non-eligible position or vice versa
- All retirements [whether enrolling in Direct Bill coverage or discontinuing SEHP coverage] (See **Chapter 18**)
- Primary members approved for disability and who wish to continue SEHP coverage (See **Chapter 18**)
- Grandchildren becoming ineligible for reasons other than the parent turning age 26
- Leave Without Pay (see **Chapter 13**)
- Death of a primary member with dependent coverage (See **Chapters 13 & 19**)
- Adding Social Security numbers or ITIN for children within 60 days of birth
- Termination of a primary member on leave of absence

Change requests are **not** required in the following situations:

- Dependents turning age 26 – SEHP Membership Services will notify the primary member and the NSE Human Resources Officer 60 days prior to the dependent's 26th birthday, when coverage terminates
- Address changes

It is the **primary member's responsibility** to keep their membership status current with their NSE. Changes **will not be made** until the Change request has been completed by the NSE

and received and approved by SEHP Membership Services. Enrollment or Change requests submitted without the appropriate supporting documentation will be denied with no action taken by the SEHP. The deadline for submitting the enrollment or change request with documentation will not be extended.

Changes in coverage that are prescribed by law or contract (i.e., dependents losing coverage due to divorce at the end of the coverage period) will take effect retroactively to the last day of eligibility regardless of when a Change request was submitted. Adjustments must be made by the NSE. Refunds should not be initiated if the employee failed to notify their NSE HR Representative of the change within 31 days of the event.

It is the **Primary member's responsibility** to:

- notify their NSE HR Representative of changes concerning name, address, marital status, geographic relocation or other applicable personal life changes
- notify their NSE HR Representative of any Change requests and submit the appropriate supporting documentation within 31 days of the qualifying event. The documentation must be legible, in English and have the primary member's name, employee ID, and the NSE group number clearly and legibly written on the documentation

It is the **NSE HR Representatives responsibility** to:

- submit the Change request for changes in eligibility, Leave Without Pay, or return from Leave Without Pay online via KEEP;
- ensure that the appropriate supporting documentation has been provided by the primary member, is legible, in English, has the primary member's name, employee ID, and the NSE group number clearly and legibly written on top of each document, and is uploaded in KEEP along with the change request;
- ensure that the NSE HR Representative acknowledged the online authorization;
- submit the Change request and appropriate supporting documentation to SEHP Membership Services within 31 days of the qualifying event.

III. INSTRUCTIONS FOR ONLINE CHANGE REQUEST

A. Before making a change request online, have this information prepared to input into the KEEP system:

- The Non State Group username and password for employer access to the KEEP website: **https://hr.hrissuite.com/console/**
- The Date of Event for the employee's qualifying event (required)
- The Employee ID number (required)
- Any documentation that may be required to process the change

B. Employee Information

Verify the following demographic information is still correct and current for the employee:

- The employee's full name (required)
- Mailing address (required)
- Contact telephone number (required)
- Social Security Number (required)
- Gender (required)
- Date of birth (required)
- Valid contact email address (required)

C. Adding Dependents

All dependent changes must be made within the appropriate SEHP guidelines. Appropriate documentation should be uploaded at the time a new dependent is added into the system. The primary member should indicate whether or not they want to:

- Add / drop dependent medical;
- Add / drop dependent dental, or
- Add /drop dependent vision coverage.

D. Dependent Information

Action – The primary member indicates whether they wish to Add or Delete a Dependent from SEHP coverage.

1. Action – Add or Delete a Dependent – Select the option that's appropriate for the primary member's requested action.
2. Relationship– (e.g. child, spouse, stepchild, etc.) The NSE HR Representative shall collect and upload supporting documentation for each covered spouse and dependent. The SEHP and/or the carrier may request documentation to support proof of relationship or dependency
3. Name – Enter the dependent's name (required)
4. Social Security Number (required) – Enter the dependent's Social Security Number or ITIN
5. Gender (required) – Select the dependent's gender
6. Date of Birth (required) – Enter the dependent's date of birth in Month / Day / Year
7. Dependent Address – The primary member must provide the dependent's address if it's different from theirs.

E. Medicare

If the primary member, spouse, and/or dependent are eligible for Medicare and are to be covered under the SEHP, the primary member should provide the following information for the NSE HR Representative to complete this section in KEEP. The member is also required to provide copies of all Medicare cards that should be uploaded via the "Upload" tab in KEEP.

- Name – last, first, middle initial;
- Hospital (Part A – month/day/year);
- Medical (Part B – month/day/year);
- Medicare Claim Number (HICN)

F. Type of Event (to be completed by the NSE HR Representative)

The NSE HR Representative indicates what the event is that is the basis for the member's request.

G. Employee and Personnel Officer Authorization – Required

The NSE HR Representative must authorize that they are entering all information in KEEP at the request of an employee of their NSE group and is complete and accurate to the best of their knowledge. They also ensure that appropriate supporting documentation is included, and that the employee agrees to the terms and conditions of the SEHP. They authorize the information submitted in KEEP will be used to determine eligibility for SEHP coverage. By this authorization they further understand that if any material information is omitted or incorrect, it could provide the basis to refuse or rescind coverage

and refund any premiums paid as though coverage had never been in force.

CHAPTER 12 - MID-YEAR ENROLLMENT CHANGES

I. ADDITION AND DELETION OF NON-NEWLY ELIGIBLE EMPLOYEES AND OTHER INDIVIDUALS

Non-newly eligible employees and other individuals are defined as:

- Employees and/or spouses and dependents for which 31 days have passed since their initial eligibility for coverage (see **Chapters 3 and 4**).
- Non-newly eligible employees and/or spouses and dependents may be added or dropped from the SEHP during the Plan Year but only if all of the following mid-year change requirements are met:
  - **A.** The change is a result of one of the events listed in Section III or IV of this chapter;
  - **B.** The change is requested, by the employee/member within 31 calendar days of the event and submitted online by their NSE HR Representative via KEEP;
  - **C.** The change in coverage is consistent with the event and complies with HIPAA regulations; and
  - **D.** Written, legible supporting documentation of the event is provided in English to SEHP Membership Services with the required deadline (divorce decree, court ordered custody agreement, or marriage certificate, etc.).

Appropriate Supporting Documentation

The following items are appropriate supporting documentation required to be submitted to the SEHP with the enrollment/change request when adding or removing other eligible individuals:

1. Marriage License in English (for proof of spouse and stepchild eligibility)
2. Birth certificate or hospital birth announcement in English for newborns including full name of the parent(s). (Birth registration cards are not acceptable proof for newborns)
3. Petition for adoption or placement agreement in English for dependent child
4. Legal custody or guardianship document in English issued by the court
5. Court order in English for dependents who are not natural or adopted children of the primary member
6. Certificate of birth in English and Dependent Grandchild Affidavit for children born to a covered dependent (grandchild) (see Appendix K)
7. An Application for Coverage of Permanent and Totally Disabled Dependent Child affidavit for covered dependent children aged 26 or older (see Appendix L).
8. Copies of the current year's filed Federal tax return (for proof of spouse eligibility only.) Please note all income information may be whited out prior to submission to SEHP Membership Services. The pages needed from the current filed Federal tax return depends on which Tax form was filed:
   - Form 1040—pages 1 & 2 containing the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
   - Form 1040A—pages 1 & 2 containing the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
   - Form 8879 (IRS e-file)—containing the date filed, the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each

signed the form.

9. Divorce decree in English (Only the first and last page of the court document are needed, but those pages must include the date stamp by the court and the signature of the judge)
10. A copy of a military ID and privilege card with the expiration date is acceptable as proof of Tricare coverage and to document the end of Tricare coverage.
11. For dependent loss of other group health coverage, a letter or certificate of other creditable coverage, listing the name of the member and all dependents that were covered under a previous employer's insurance is required. The letter or certificate must identify the previous employer, and list the date in which coverage ended.

NOTE: In order to match other eligible individual documentation to the appropriate primary member, the NSE HR Representative must verify prior to sending the documentation to the SEHP, that documentation is legible, provided in English, and that the primary member's name, employee ID, and the NSE group number is clearly written on top of each document.

Additions: If dependent medical coverage is added, then dependent dental coverage may be added at the same time. If dependent dental coverage is elected, the level of dependent dental coverage must match the dependent medical coverage level. **If the primary member currently has any level of dependent medical, but has primary member only dental, they may not elect to add dependent dental even with a qualifying event.**

Vision coverage may be added during the Plan Year only for newly eligible employees and/or dependents. Primary members cannot change from Basic to Enhanced vision coverage, or vice versa during the Plan Year.

If the primary member has waived vision coverage, newly eligible dependents may not be added even if a qualifying event occurs.

Deletions: Primary members who are enrolled on an after-tax basis may drop primary member or dependent coverage (both medical and dental) without restriction during the Plan Year.

Dependent dental coverage may not be dropped during the Plan Year unless dependent medical coverage is also dropped.

Vision coverage may not be dropped during the Plan Year unless due to an ineligible primary member and/or dependent. Even if a primary member is enrolled on an after tax basis, vision coverage cannot be dropped during the Plan Year.

II. EFFECTIVE DATE OF COVERAGE

For mid-year enrollment changes, the effective date of coverage or change in coverage will generally be the first day of the month following the event (assuming approval by SEHP Membership Services). For events that occur on the first day of a month, the coverage effective date will be that day. However, if a death occurs on the first day of a month, the change effective date will be the first day of the following month.

In **Chapter 4, Section III B**, the effective date of coverage is outlined for newborns, adopted children, new spouses and/or new stepchildren, and changes in legal custody or guardianship of a dependent.

If a primary member is enrolled on an after-tax basis, and is dropping primary member and/or dependent coverage, the effective date of change in coverage is the first day of the month following completion of the Change request and approval by SEHP Membership Services. If the Change request is completed on the first day of a month, the coverage effective date will be that day.

The effective date of coverage or change in coverage is outlined in **Chapter 6** for changes in Medicare eligibility.

III. PRE-TAX EVENTS

If a primary member is enrolled on a pre-tax basis, and any addition or deletion to coverage will result in a change in employee contribution, there must be a qualifying event for the change to be approved. Enrollment changes must also be consistent with the event and must comply with HIPAA regulations. Primary members may change pre-tax status only during Open Enrollment each year (unless the 30 day waiting period was waived for initial enrollment). The change in status event must result in a gain/loss/change of coverage in an **employer-sponsored group health insurance plan**. This gain/loss/change can be for the employee, spouse, or dependent and can be under either the SEHP or a plan sponsored by the spouse or dependent's employer. The requested change of election must then correspond with the gain/loss/change of coverage, and must be confirmed with documentation in the form of a letter from the NSE on the NSE's letterhead. All change requests must be submitted online via KEEP within 31 days of the event.

Primary members who are enrolled in the SEHP on a pre-tax basis may make mid-year additions and deletions from coverage based on the following events and subject to the requirements listed in **Section I**:

- **A.** Employee's marriage – the member may add or drop entire family if the family is picked up under the new spouse's employer's plan because the entire family is now newly eligible (see **Chapter 4, Section III**). The entire family is not newly eligible for SEHP coverage if the spouse's employer covered unmarried domestic partners. If the marriage is a common law marriage, a notarized copy of the Affidavit of Common Law Marriage (**Appendix M**) must be submitted with the enrollment/change online request.
- **B.** Final divorce (the first and last pages of the final divorce decree including court recorded date stamp and judge's signature must be submitted with the enrollment/change request).
- **C.** Birth or adoption of a dependent child – the primary member may add their entire family. They may drop entire family only if the qualifying event is due to a birth or adoption, and those family members are now newly eligible under some other employer sponsored group health insurance plan (see **Chapter 4, Section III**).
- **D.** Gain or loss of legal custody of a dependent child. (A copy of the court order including court recorded date stamp and judge's signature must be submitted along with the online change request).
- **E.** Change from part-time to full-time or from full-time to part-time employment by employee, spouse or dependent child that affects cost, benefit level, or benefit coverage for employee, spouse and/or dependent child(ren).
- **F.** Change from benefits eligible position to benefits ineligible position by the employee, spouse or dependent child.
- **G.** Retirement (Termination or commencement of employment) of employee. An employee can change their medical plan at the time or retirement. **See Chapter 18, Section III**
- **H.** Death of employee and surviving spouse/dependents which to continue coverage under the Direct Bill program. **See Chapter 18 for additional information**.
- **I.** Employee, spouse or dependent's gain or loss of employment which affects benefits coverage for employee, spouse and/or dependents. Any employment status changes that affect eligibility. If the gain or loss of coverage for the individual is with the SEHP, that must be indicated on the online change request. **For spouse or dependent loss**

of other group health coverage, a letter or certificate of other creditable coverage, listing the name of the member and all dependents that were covered under a previous employer's insurance is required. The letter or certificate must identify the previous employer, and list the date in which coverage ended.

J. Unpaid leave of absence by employee, spouse or dependent which affects the benefits coverage of employee, spouse and/or dependents. If the employee wishes to continue coverage during this leave of absence that must be indicated on the online change request. **See Chapter 13** for additional information. If the employee is rehired or reactivated within 30 days, he/she must return to the same plans and coverage levels unless he/she experiences a status change event.

K. Return from leave without pay. Please see **Chapter 13** for additional information.

L. An employee can make a mid-year change during a spouse's or dependent's Open Enrollment period due to significant changes to a spouse's or dependent's employer sponsored group health insurance plan, such as premium increases or benefit plan changes. Exhaustion or termination of spouse's or dependent's COBRA continuation coverage under their employer sponsored group health insurance plan constitutes a qualifying event. A change or loss of employer's contribution/subsidy to a spouse or dependent's COBRA continuation coverage prior to exhaustion of COBRA continuation coverage does not constitute a qualifying event. A change of network status of a physician is not a qualifying event.

M. Employee, spouse or dependent being called to active military duty and/or gaining or losing eligibility for military insurance.

N. Loss of COBRA eligibility (for other than non-payment of premium) from a previous employer for an employee, spouse or dependent.

O. Employee, spouse or dependent gaining or losing government-sponsored medical card coverage, although terminating coverage is not allowable if the employee becomes covered under programs like SCHIP (State Children's Health Insurance Program) because these programs are not supposed to replace existing insurance. This may apply to other government card coverage.

P. Dependent turning age 26 (coverage will end the last day of the month of the birthday). If the birth date is on the first day of a month, the coverage ending date for that dependent will be the last day of the preceding month.

Q. Removal of ineligible grandchild—Refer to Chapter 4, Section F for eligibility requirements for grandchildren.

R. Employee, spouse or dependent losing Medicare eligibility or becoming eligible for Medicare, and electing Medicare coverage as primary (see Chapter 6).

S. Death of a spouse or dependent

T. Dependent children identified under a Medical Withholding Order (K.S.A. 23-4,105) or Qualified Medical Child Support Order (the SEHP has the authority to add these dependent children without the consent of the employee).

U. Dependent children losing eligibility/coverage under another employer sponsored group health insurance plan. For dependent loss of other group health coverage, a letter or certificate of other creditable coverage, listing the name of the member and all dependents that were covered under a previous employer's insurance is required. The letter or certificate must identify the previous employer, and list the date in which coverage ended.

V. Dependent spouse or children who move to the U.S.— Please select "Other" as type of event and indicate dependent spouse and/or child moving to the U.S.

IV. AFTER-TAX EVENTS

Members who are enrolled in SEHP coverage on an after-tax basis may make mid-year additions and deletions from coverage due to the following events and subject to the requirements listed in **Section II**:

A. All events as listed under Pre-tax Events;

B. Removing employee, spouse, and/or dependents from SEHP coverage for any reason.

C. Vision coverage may **NOT** be added or dropped during the Plan Year.

V. RETIREMENT

When an employee retires from a participating NSE group, the employee must contact their NSE HR Representative to terminate their active SEHP coverage and decide whether or not they wish to continue SEHP coverage with the State of Kansas through the Direct Bill program. They will also be offered COBRA continuation coverage. If they wish to continue coverage through the Direct Bill program, the employee should ignore the COBRA notice. For additional information on the Direct Bill program (see **Chapter 18**). Members must have continuous coverage under the SEHP to be eligible for the Direct Bill program. If continued coverage is desired, an online Change request should be completed 31 days before the employee's retirement in order to ensure continuous coverage between active employee coverage and Direct Bill coverage. After a Retirement request has been approved, the HR Representative must forward on the enrollment portal website to the retiring member so they may access the enrollment portal and make their initial retirement elections.

The effective date of change to the Direct Bill program will be the first day of the month following the employee's last day at work. The retiree will receive a bill for the first full month in retirement status. For the next month and after, individuals enrolled in the Direct Bill program must pay by bank draft if the bank draft information is received by the premium billing vendor. Deductions will be made from the individual's bank account on approximately the 3rd of the month for that month's coverage (i.e. January 3rd for January's coverage).

The employee may change their medical plan at the time of retirement. Dependents may be dropped from coverage upon retirement; however, dependents may be added to coverage only if there is a qualifying mid-year event (see **Chapter 12**). Dependents may also be added to coverage during the next Open Enrollment period. If the employee or covered spouse is age 65 or over when the employee retires, refer to **Chapter 18**.

Also see the online User Guide for making a Retirement change in KEEP

VI. ACTIVE MILITARY DUTY

These procedures apply only if the participating Non State Employer Group wishes to cease employer contribution when an employee is on military leave. Employee coverage ends effective the last day of the month in which the employee goes on military leave. Employees on military Leave Without Pay may continue coverage for the next 30 days. The NSE will continue to make the SEHP employer contribution for those 30 days. The employee is required to remit his/her premium (regular payroll deduction amount) to the NSE to retain coverage during the 30 days following the effective date of the military Leave Without Pay. If the Non State Employer wishes to continue paying the SEHP coverage premiums, they should continue to do so. No additional requests or information need to be sent to the SEHP

Employees may continue coverage in the SEHP beyond the 30 days Leave Without Pay timeframe if the Non State Employer discontinues making employer contributions to coverage, but the employee must remit the full premium amount directly to the premium billing vendor as a Direct Bill participant. There will be no Non State Employer contribution.

An employee with spouse, children, or full family coverage may elect to drop themselves and keep their spouse and/or children covered in the SEHP. Employees must make the change within 30 days of the effective date of the military Leave Without Pay. To continue SEHP coverage, an online Change request indicating Leave Without Pay must be completed and submitted to the SEHP Membership Services.

Employees are also eligible for 24 months of COBRA coverage.

If SEHP coverage is continued, it will be the primary payer of claims and their military coverage will be secondary.

Primary members, their spouses and/or dependents who elect to discontinue SEHP coverage and who have primary coverage provided by the military will be allowed to re-enroll into the same SEHP plan and coverage when they return to active employee status.

Employees on military leave during Open Enrollment may enroll in any SEHP plans and coverage levels for which they are eligible, without penalty, upon their return to active employee status. The effective date of coverage may be either the first day of the month following the employee's return from active military duty or the first day of the month in which the employee returns to active employee status, whichever the employee chooses.

If an employee is qualified for and elects to participate in the military's transitional health benefit program, the employee will be allowed to reinstate SEHP coverage without penalty when the transitional coverage terminates. The employee may be qualified for up to 180 days of transitional health benefits.

The effective date of coverage may be either the first day of the month following termination of the military transitional health coverage or the first day of the month after the date the member returns to work, whichever the employee chooses.

Return from military leave policies also apply to spouses and dependents returning from military leave.

VII. TREATMENT FOR MEMBERS AND THEIR ELIGIBLE SPOUSE AND DEPENDENTS WHILE TRAVELING OUTSIDE OF THE U.S.

Members should contact their plan carriers **before** traveling outside of the U.S. for coverage and claim submission requirements in the event the member and/or their eligible spouse and dependents needs to seek medical treatment while traveling outside of the U.S. Each plan carrier has their own processes and procedures to ensure the member and/or their eligible spouse and dependents have appropriate coverage while traveling.

VIII. PRESCRIPTION DRUG ADVANCE PURCHASE POLICY

A. Travel in the United States

Because the SEHP uses the Caremark Pharmacy network, active members traveling within the United States are not eligible for an advance purchase. SEHP active members may use their drug card at any Caremark network pharmacy throughout the U.S.

B. Travel Outside of the United States

1. **Travel or work outside the U.S. for a period of sixty (60) days or less:**
   Members that leave the U.S. for 60 days or less may call the TOLL-FREE number on the back of their card to arrange for a vacation supply of medications. Caremark may enter up to 30 days on an original fill for non-controlled and controlled medications or a 60 day override on refills of medications as allowed by the benefit description. The member will be billed the applicable coinsurance or copayment for the quantity purchased.

2. **Work outside the U.S. for a period of sixty (60) days or longer (but not to exceed one (1) year):**
   This policy and its provisions apply only to active employees covered under the SEHP. When a member will be outside of the country for a longer period of time, there are two options available:
   - **Advance purchase through drug plan:**
     The member must work with the NSE's personnel/benefits office to arrange for advance purchase of maintenance medications required during a stay outside the U.S. The Advance Purchase Form certifying that health coverage will be maintained during the entire period of the extended absence must be signed by both the member and the NSE Human Resources representative. An Advance Purchase Form must be submitted to the SEHP **at least fifteen (15) days prior to departure date**. The NSE and the member will be notified when the Advance Purchase Form has been processed and the dates the medication will be available to pick up. Generally, the medication will be available for purchase one week in advance of the departure date. The following requirements apply:
     a. The Advance Purchase form must be completed stating that coverage will be maintained via payroll deductions during the term outside of the U.S. The form also requires information on destination and duration of stay. The Advance Purchase form signed by the member and the NSE representative acknowledges the SEHP's right to recovery from the NSE group and/ or employee the cost of the medications if coverage is not maintained.
     b. The name and strength of each requested medication and the name of the prescribing doctor must be on the Advance Purchase form. For each medication, provide the name of pharmacy where the medication will be filled. The member will be responsible for the applicable coinsurance percentage on the cost of the quantity of drug dispensed. The member must agree to purchase the prescription medication at a local network pharmacy. Members or their dependents using the Caremark mail service will need to obtain a prescription from their doctor so that the items can be purchased at a local network pharmacy.

     REMINDER: Medication can only be dispensed for the period of time allowed by the prescription written by the provider. For extended periods, the member may need a new prescription. Advance purchases are available for period up to one (1) year.
     c. Benefits available for emergency prescriptions purchased outside of the U.S. will be limited to those drugs which would have been covered had they been purchased within the U.S. Documentation of the purchase must be translated into English along with the exchange rate on the date of service and be submitted to the SEHP on a paper form (see **Appendix H**) with a statement indicating their purchase and use while outside of the U.S. Membership status will be verified and the claim will be forwarded to Caremark for reimbursement.
   - **Member purchases medication(s), then submits claim(s) upon return:**
     If the member does not have enough time to file an Advance Purchase Form in advance of their departure, they may pay the full price for their medications, and file a paper claim for reimbursement upon their return. The paper claim would need to be filed first to SEHP for processing.

   For additional information, refer to Appendix G-1.

IX. DEATH OF A PRIMARY MEMBER WITH DEPENDENT CHILDREN

In the event of the death of a primary member who only had dependent child(ren) covered under their SEHP coverage, the surviving dependent child(ren) may elect to continue coverage under the SEHP Direct Bill program until they no longer meet the definition of an eligible dependent (i.e., the child reaches the limiting age of 26).

The eligible dependent child(ren) or authorized representative for the eligible dependent child(ren) must contact the NSE HR Representative within 31 days of the death of the primary member in order to elect to continue coverage under the Direct Bill program. If elected, the Direct Bill coverage will be set up under the youngest eligible dependent child as the primary member with other eligible dependent child(ren) set up as dependents under that new primary member.

CHAPTER 13 - LEAVE WITHOUT PAY AND FAMILY MEDICAL LEAVE ACT (FMLA)

The Federal Family and Medical Leave Act (FMLA) became effective August 5, 1993.

I. APPROVED LEAVE WITHOUT PAY

If a member is on voluntary or involuntary Leave Without Pay and the leave is not approved as FMLA AND the Non State Employer does not continue to make employer contributions to the SEHP coverage, the NSE HR Representative must submit an online change request terminating the coverage the first of the month following the last date the employee was working. The Non State Employer must notify the member that their SEHP coverage as an active employee will end effective the last day of the month that the employee went on Leave Without Pay status unless the member signs up for Direct Bill.

The Non State Employer must treat an employee on FMLA as an active employee, making employer contributions for coverage for 12 weeks. No additional requests or information needs to be sent to SEHP Membership Services unless the member terminates coverage for any reason.

If the Non State Employer wishes to continue making employer contributions to the employee's SEHP coverage, they must also collect the employee's portion of the premium and submit premiums as normal to the SEHP's premium billing administrator. No additional requests or information needs to be sent to SEHP Membership Services unless the member terminates coverage for any reason

A. Non-Payment of Active Non State Employee Premium

If the employee fails to pay on schedule, the NSE shall submit an online Change request to SEHP Membership Services canceling the employee's coverage. The employee will not be offered COBRA continuation coverage and will not be allowed to re-enroll in active or Direct Bill coverage for the remainder of the Leave Without Pay period.

If the Non State Employer fails to submit an online Change request, it will be assumed the employee is still an active employee. If the Non State Employer fails to notify SEHP Membership Services of any cancellation within 31 days of the qualifying event, the Non State Employer shall be assessed a fee of $200.00 per member per month for every month the notice is not received by SEHP Membership Services. The notice must be received via an online Change request in KEEP. The assessment itself is made payable to SEHP and sent to SEHP Membership Services.

B. Continuing under the Direct Bill Program

If the employee elects to continue under the Direct Bill program, coverage will begin the first day of the month following the last day of work or the end of the month the NSE stopped making employer contributions to the SEHP coverage. A bill will be generated by SEHP's Direct Bill premium billing vendor, and sent to the member's home address the middle of each month before the Direct Bill premium for coverage is due. Premiums are due the first of the month for that month's coverage. The member pays the entire monthly premium (member and NSE portions) while on Direct Bill coverage.

C. Employee's Premium Responsibility

Non State Employer contributions toward coverage will be reinstated the first day of the month following the date in which the member returns to active status. If the member

returns to work on the first day of a month, Non State Employer contributions will be reinstated that day. Once payroll deductions resume, the member will be refunded the Direct Bill monthly premium if payment has already been made for that month.

D. Billing and Payment Procedure

After the online Change request is received and processed by SEHP Membership Services, they will forward the enrollment change to the Direct Bill premium billing vendor. SEHP's Direct Bill premium billing vendor will calculate the necessary premium amounts and will send a bill to the member's last known home address. If the member desires to continue coverage, the member then remits the amount due. The Direct Bill monthly premiums are paid by the employee until the employee returns to work. Premiums are due on the first of each month for coverage for that month.

E. Continuing Coverage

Primary members can elect to continue their SEHP coverage while on leave without pay under the Direct Bill program. They can change their medical plan and/or carrier, drop their dental, and change their coverage level but, only to reduce a coverage level (cannot add/increase coverage level). If reducing coverage levels on medical and dental, and they are currently enrolled in vision coverage, they can reduce their vision coverage level to match the medical and dental levels. If currently enrolled in primary member only vision coverage, the primary member cannot change their vision plan benefits or drop vision coverage. They may drop vision coverage at the next Direct Bill Open Enrollment.

Employees who are 65 or older are not required to enroll in Medicare, as they are still considered Active employees expected to return to work at a later date.

F. Non-Payment or Late Payment of Premium

If any Direct Bill payment is not received within 15 calendar days of its due date, coverage will be terminated effective the first day of the month for which the payment was due.

II. RETURN FROM LEAVE WITHOUT PAY

When an employee returns from Leave Without Pay, an online Change request must be completed and submitted to SEHP Membership Services within 31 days of the date of return to active pay status;

A. If an eligible employee returns from Leave Without Pay, and it did not extend over an Open Enrollment period, an online Change request must be submitted. A Change request should be completed to enroll the member (and dependents if previously enrolled prior to leave without pay) in the same medical, dental and vision (if applicable) benefit plan and carrier they were enrolled in prior to the Leave without Pay. Select the "Return from Leave Without Pay" option on the change request. The employee must enroll on a pre-tax basis in the same Plan Year if they were paying on a pre-tax basis before they went on Leave Without Pay. If spouse or dependent coverage was dropped during the Leave Without Pay resulting in a reduction in coverage:

1. The employee may add the previously covered spouse and dependents to coverage; or
2. The employee may continue single coverage upon return to active pay status.

The effective date of coverage will be the first day of the month following the employee's return to active pay status. If the employee returns on the first day of a month, coverage will begin that day.

B. If the employee was on leave during Open Enrollment, or their premiums are not currently paid in full, an Enrollment request; “Return from Leave" must be submitted via KEEP indicating the return date to active pay status. The effective date will be the first day of the month following the employee's return to active pay status. If the employee returns to work on the first day of a month, coverage will begin that day. The employee cannot change their medical plan and carrier unless the period of Leave Without Pay extended over Open Enrollment.

III. FMLA - APPROVED LEAVE WITHOUT PAY OF 31 DAYS OR MORE

If the employee is eligible for FMLA and has a qualifying condition as outlined in the FMLA, they are eligible for 12 weeks of paid or unpaid leave; during any 12-month period beginning with the first day leave was taken.

Documentation of leave under FMLA should be retained by the Non State Employer. When an employee goes on Leave Without Pay under FMLA, the NSE HR Representative must submit an online Change request for "Leave Without Pay” only after all leave under FMLA has been exhausted by the employee and the Non State Employer wishes to discontinue making employer contributions to the employee’s SEHP coverage.

A. Billing and Payment Procedure

Premiums should continue to be deducted from the employee’s paycheck for as long as the employee continues to receive a paycheck that is sufficient to take the SEHP deduction. When the payroll deduction is no longer taken, the employee is responsible for remitting the employee contribution amount due directly to the Non State Employer.

B. Changes in Coverage Level

A member on continuation under FMLA during Open Enrollment may also make changes to their SEHP coverage.

In addition, a member with a qualifying event may make the appropriate additions and/or deletions to coverage (e.g., adding a newborn child to coverage). Changes should be sent via an online Change request to SEHP Membership Services.

IV. RETURN FROM FMLA - LEAVE WITHOUT PAY

If an employee returns to work, but was terminated for non-payment of premium while on FMLA, they may re-enroll in their previous coverage. The effective date of coverage will be the first day of the month following the employee’s return to active employment. If the employee returns to work on the first day of a month, coverage will begin on that day.

CHAPTER 14 - RETROACTIVE ENROLLMENTS

Retroactive enrollments are those in which notification is not made to the SEHP within 31 days from the date of the qualifying event. Retroactive enrollments are also those in which notification is not received by the medical plans within 60 days of the date of the event.

REMINDER: Changes will not be made until a completed online Change or Enrollment request is submitted to SEHP Membership Services. **Changes in the monthly billing amounts remitted or on the billing statements themselves will not be accepted as fulfilling the Non State Employer Group's responsibility to notify the SEHP of a request for coverage changes. The Non State Employer Group will be responsible for all premiums that result from failure to provide proper notice to the SEHP in a timely manner.**

Due to contractual agreements with the medical plans, retroactive enrollments must be processed as follows:

I. RETROACTIVE ENROLLMENT TERMINATIONS

Retroactive enrollment terminations are processed due to late notification of a qualifying event if the member **does not** wish to continue with the SEHP (e.g. termination, death, retirement, Leave Without Pay, or change to an ineligible position). The termination will be made effective as of the first day of the month following the date of the qualifying event. **However, failure of the NSE to notify the SEHP of any termination within 31 days of the qualifying event shall result in the assessment of a fee of $200.00 per member per month for every month the notice is not received by SEHP Membership Services.** The notification must be submitted to SEHP Membership Services via an online Change request. The SEHP will notify the Non State Employer Group of penalty amounts due.

Example: An employee terminates employment on April 19, 2xxx but the NSE does not submit the online change request until October 18, 2xxx. The effective date of termination is April 30, 2xxx; **however, the NSE is responsible for the assessment fee of $200.00 per month from May through October.**

In the event that SEHP does not receive timely notification of a termination of employee/spouse/dependent benefits and the employee/spouse/dependent is eligible for and wishes to continue SEHP coverage under the Direct Bill program, retroactive enrollment may be allowed. The enrollment in the Direct Bill program will be made effective as of the first day of the month following the date of the qualifying event.

However, failure of the Non State Employer to notify the SEHP of any cancellation within 31 days of the qualifying event shall result in the Non State Employer being responsible for the member/spouse/dependent's Direct Bill premiums for every month the notice is not received. The notice must be submitted via an online change request to SEHP Membership Services. The SEHP will notify the Non State Employer of penalty amounts due.

Example: An employee goes on Leave Without Pay effective April 19, 2xxx, but the Non State Employer does not notify SEHP Membership Services (by submitting an online Change request) until October 18,2xxx. The effective date of Leave Without Pay is May 1, 2xxx; **however, the Non State Employer is responsible for the back Direct Bill premiums from May through October.**

II. RETROACTIVE ENROLLMENT / ADDITIONS

The NSE must make requests for late retroactive enrollment additions on NSE letterhead. If a late retroactive enrollment addition is approved, the NSE is responsible for payments of the retroactive premiums from the effective date of coverage up to the date the enrollment addition is processed by SEHP Membership Services.

After 60 days have passed from the effective date of coverage, retroactive additions to coverage may be made on any medical, prescription drug and dental plan if a Communication Form **(See Appendix F)** is submitted to and approved by SEHP Membership Services. **Retroactive vision enrollment will not be approved.**

If necessary, the employee must request their NSE Human Resources Representative to complete an online revised enrollment request in order for the retroactive enrollment to be considered and processed. If a revised Enrollment request is required, the SEHP will notify the NSE HR Representative.

Example: A benefits eligible employee is hired on April 19, 2xxx and eligible for SEHP coverage effective July 1, 2xxx. The NSE HR Representative sends the online Enrollment request to SEHP Membership Services on September 10, 2xxx. Because the effective date of coverage is more than 60 days prior to the date of request, a communication form must be sent to SEHP Membership Services requesting a revised online Enrollment request effective July 1, 2xxx.

III. ENROLLMENT CHANGES DUE TO INELIGIBLE SPOUSE/DEPENDENTS

If a retroactive enrollment change is processed due to late notification of an ineligible spouse/dependent, the enrollment change will be made effective the first day of the month following the date of the event. Refunds will not be processed due to late notification.

CHAPTER 15 - TERMINATION OF COVERAGE

I. GROUP TERMINATION

The participating Non State Employer Group is responsible for advising terminating employees when their coverage will end. The participating Non State Employer Group's coverage through the SEHP terminates on the earliest of the following dates:

A. Upon termination of the SEHP group policy;
B. Upon non-payment of the required group premiums;
C. The date the Non State Employer Group ceases to participate in the SEHP; or
D. On the date the participating NSE Group breaches its contract with the SEHP. This includes failing to maintain the participation level required by the contract.

NSE groups are required to complete a SEHP Certification Form (see Appendix U) and submit it to the SEHP by January 1 each year documenting their participation levels in the SEHP.

NOTE: IN THE EVENT OF THE NSE GROUP'S TERMINATION FROM THE SEHP, IT IS THE RESPONSIBILITY OF THE NSE TO CONTACT ALL DIRECT BILL, RETIREES AND COBRA PARTICIPANTS OF THE GROUP'S TERMINATION. ALL OF THE NSE'S MEMBERS WILL BE TERMINATED THE SAME DAY AS THE GROUP.

II. EMPLOYEE TERMINATION

The Non State Employer Human Resources Officer is responsible for advising terminating employees when their SEHP coverage will end. SEHP coverage for an employee terminates on the earliest of the following dates:

A. When the group policy terminates;
B. On the last day of the month for which premium payment was last received for the employee;
C. On the last day of the month in which the employee becomes ineligible for benefits; or
D. On the last day of the month in which an employee terminates employment except those:
  1. Employees whose spouse is also employed by another NSE and has enrolled the former employee as a dependent; or
  2. Employees who are eligible to continue upon cessation of active work:
    a. Employees granted Leave Without Pay.
    b. Individuals who are eligible to continue coverage by reason of retirement as indicated by K.A.R. 108-1-3 and 108-1-4.
    c. Twelve (12) month contract teachers.

If the terminating employee is Medicare eligible for any reason, (age 65, disabled, etc.), the NSE must provide them with a Memo for Medicare Part B, (Appendix I), on the NSE's letterhead. This Memo is for the employee to provide to the Social Security Administration to allow them to apply for Medicare without incurring any penalties. The memo should be provided to the employee upon their termination, or mailed to the employee's last known address.

III. OTHER ELIGIBLE INDIVIDUALS TERMINATION

SEHP coverage for other eligible individuals terminates on the earliest of the following dates:

A. When the group policy terminates;

B. The last day of the month in which an employee's coverage terminates; or

C. The last day of the month in which the individual ceases to be an eligible spouse or dependent under the SEHP's definition of an eligible spouse or dependent.

For terminations other than termination of employment, if the event that causes the spouse or dependent to lose eligibility occurs on the first of the month, then that is the last day of coverage.

Examples (but not limited to these situations):

- Dependent turns 26 on August 1; their coverage terminates on August 1.
- Divorce occurs on August 1; spouse's coverage terminates on August 1.

If the member's spouse or dependent is terminating SEHP coverage and is Medicare eligible for any reason, (age 65, disabled, etc.), the NSE must provide the member with a Memo for Medicare Part B, (Appendix I), on the NSE's letterhead. This Memo is necessary for the spouse/dependent to provide to the Social Security Administration to allow them to apply for Medicare without incurring any penalties. The Memo should be provided to the member upon the termination of the spouse/dependent, or mailed to the member's last known address.

CHAPTER 16 – BILLING AND PAYMENT

I. BILLING AND PAYMENT FOR PARTICIPATING NON STATE EMPLOYER GROUPS

The SEHP uses HP Enterprises, Inc. as its third party billing administrator for participating Non State Employer Groups. HP Enterprises, Inc. sends the billing statement to participating Non State Employer Groups around the 25th of the month prior to the coverage period. Non State Employer Groups may also sign up for automatic draft payment through HP Enterprises, Inc.

The billing cycle ends the 14th day of each month. Any changes, adjustments or additions to an employee's benefits that are received and processed after the 14th of the month will be reflected the following month in the adjustment section of the billing report.

Payment is due by the first day of the month for the month's coverage period. Any payments received on or after the 15th day of the month are considered late. Any remaining balance due as of the 15th day of the month will be assessed a 2.5% late payment penalty that will be due on the next month's billing cycle.

The billing statement includes a detailed list of covered members, their enrollment level and amount due for coverage as the 14th day of the previous month. The NSE group must pay the total amount invoiced each month to prevent late payment penalties. The NSE Group should not change the amount paid and pay what they feel is correct. If the NSE Group pays less than the amount billed, they will be assessed the late payment penalty on the next month's billing cycle.

The Non State Employer Group must ensure that any changes for employees' coverage are submitted via KEEP as outlined in Chapters 3, 4, 10 and 11.

Payment checks should be made out to "HP Enterprises, Inc." and sent to HP at the address listed on the billing invoice.

REMINDER: Changes in coverage will not be made until the completed enrollment or change request is received and approved by SEHP Membership Services. Adding or deleting an employee off the monthly billing or indicating changes in coverage levels or benefits on the monthly detailed statement will not be accepted as fulfilling the NSE groups' responsibility to submit enrollment and change requests via KEEP within the required deadlines. Paying amounts less than invoiced will result in late payment penalties.

CHAPTER 17 - HIPAA

I. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. HIPAA places requirements on employer-sponsored group health plans, insurance companies and health maintenance organizations that:

- limit exclusions for pre-existing conditions;
- prohibit discrimination against employees and dependents based on their health status; and
- guarantee renewability and availability of health coverage to certain employees and individuals.

A. PRE-EXISTING CONDITION EXCLUSIONS

Prior to HIPAA, group sponsored plans limited or denied coverage of conditions that were present prior to an individual's enrollment in that health plan. These restrictions were referred to as "pre-existing condition exclusions". HIPAA places strict limitations on such exclusions. For example, plans are required to provide notice of pre-existing condition exclusions; a pre-existing condition exclusion must relate to a condition for which medical advice, diagnosis, or treatment was recommended or received during the 6-month period prior to an individual's enrollment date in the plan; coverage can only be excluded for a maximum period of 12 months (18 months for late enrollee), and reduce the 12/18 month exclusion period by the amount of time an individual had certain other insurance coverage (called "creditable coverage"). Other benefit limitations or restrictions may apply under health plans, such as the Uniformed Services Employment and Reemployment Rights Act (USERRA), which can affect the application of pre-existing condition exclusion to certain individuals who are reinstated in a group health plan following active military service. With HIPAA, certain people and conditions can never be subject to pre-existing condition exclusion, for example pregnancy. Under HIPAA, the enrollment date is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

B. CREDITABLE COVERAGE

The group health plan is required to furnish a certificate of coverage automatically when coverage terminates either with the SEHP or when coverage is lost under COBRA continuation, as well as upon an individual's written request at any time while that person is covered by a plan or up to 24 months after coverage ceases. Plans are also required to use reasonable efforts to determine information needed to complete a certificate for a dependent. Creditable coverage is coverage under most health benefit programs, including employer or multiemployer group health plans, individual health insurance policies, COBRA continuation coverage, Medicare, Medicaid, and state and local government programs, including health coverage provided by SCHIP and by a foreign government. Certification will be sent to the individual or dependent at their last known address and will identify the covered person, the period of coverage, any waiting periods, and will include an educational statement to inform recipients of their HIPAA rights, and information about FMLA coordination. Also under the Trade Act of 2002, workers qualifying for the provisions of the Trade Act have a second opportunity to elect COBRA after an original qualifying event.

C. SPECIAL ENROLLMENTS

HIPAA requires that group health plans allow certain individuals to enroll without having to wait for late or open enrollment. These special enrollment periods are for (1) employees who previously declined coverage for themselves and their dependents and then lost coverage, (2) or if an employee adds a dependent by marriage, birth, adoption or placement for adoption. The employee needs to complete enrollment within 31 days after their other coverage ends. Written documentation of loss of other employer sponsored group health coverage, the marriage, birth, adoption or placement for adoption must be provided. (Please refer to **Chapter 4 and 12** for more information).

Some examples where special enrollment may apply are: 1) ceasing to be eligible under a plan due to cessation of dependent status (e.g. a child aging out of dependent coverage); 2) reaching a plan's lifetime limit on all benefits; 3) a plan ceasing to offer any benefits for a class of similarly situated individuals (e.g. all part-time workers); and 4) an employer of another plan stops contributions toward other coverage, even if the individual continues the other coverage by paying the amount that used to be paid by the employer.

D. NON-DISCRIMINATION REQUIREMENTS

Individuals may not be denied eligibility or continued eligibility to enroll for benefits under the terms of the plan based on specified health factors. In addition, an individual may not be charged more for coverage than similarly situated individuals on these factors. These factors are: health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, and evidence of insurability or disability. For example, an individual cannot be excluded or dropped from coverage under the health plan just because the individual has a particular illness.

E. OTHER APPLICATIONS OF HIPAA LAW

HIPAA provisions also apply to services under the following laws: 1) Women's Health and Cancer Rights Act (WHCRA) which provides protections to patients who choose to have breast reconstruction in connection with a mastectomy; 2) Mental Health Parity Act (MHPA) which prevents the group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower - less favorable - than annual or lifetime dollar limits for medical and surgical benefits offered under the plan; and, 3) Newborns' and Mothers' Health Protection Act (NMHPA) which affects the amount of time the member or beneficiary and newborn child are covered for a hospital stay following childbirth. For the mother or newborn child, that includes no restriction to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. Nor is it required that a hospital obtain authorization from the medical plan for prescribing a length of stay not in excess of the above periods.

F. PLAN DISCLOSURE REQUIREMENTS

Under the Department of Labor's (DOL) rules governing plan disclosure requirements, group health plans must improve the summary plan descriptions and summaries of material modifications in the following ways: **1)** Notify members and beneficiaries of any material reductions in covered services or benefits within 60 days of adoption of the change; **2)** Disclose information about the role of insurance companies and health plans with respect to the group health plan, specifically the name and address, and to what extent benefits under the plan are under a contract, and the administrative services, such as paying claims; **3)** Inform members and beneficiaries which DOL office they can contact for assistance or information on their rights under HIPAA; and 4) Inform members and beneficiaries that federal law prohibits the plan and health

insurance issuer from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections.

G. PLAN MEMBERS RIGHTS

Should a member have questions about their rights under HIPAA, they may contact the following office:

U.S. Department of Labor
Employee Benefits Security Administration
City Center Square, 1100 Main Street
Kansas City, Missouri 64105 Telephone: 816-426-5131

The member may also contact:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210

II. HIPAA ADMINISTRATIVE SIMPLIFICATION

The Administrative Simplification provisions of the HIPAA (Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards improves the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

A. PRIVACY REGULATIONS

The privacy regulations (effective April 14, 2003) ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. Key provisions of these standards include: 1) Access to medical records; 2) Notice of privacy practices; 3) Limits on use of personal medical information; 4) Prohibition on marketing, and stronger state laws; 5) Confidential communications; and 6) Where to file complaints.

B. SECURITY REGULATIONS

The HIPAA Security requirements (effective April 20, 2005) ensure confidentiality of electronic protected health information that the health plan creates, receives, maintains or transmits.

C. SPECIAL NOTES:

- At times it may be necessary to obtain information regarding a member's protected health information. SEHP will request that the member complete an Authorization for Release of Protected Health Information form (see **Appendix R**).
- Members may complete an Appointment of Personal Representative Form (see **Appendix S**) and submit it to SEHP Membership Services to allow another individual to discuss and act on behalf of that member regarding their coverage under the SEHP. Without this form, the SEHP will not discuss anything or act upon any requests from any individual other than the member regarding a member's SEHP coverage.
- If a member currently has a Personal Representative Form on file with the SEHP and no longer wishes to have that individual act on behalf of a member, the

member must submit a Revocation of Personal Representative Form (see **Appendix S-1**) to SEHP Membership Services.

CHAPTER 18 - CONTINUATION OF COVERAGE – DIRECT BILL PROGRAM

I. MEMBERS ELIGIBLE TO CONTINUE IN THE DIRECT BILL PROGRAM

Eligible members may continue coverage through the SEHP after they retire from the participating Non State Employer Group. Coverage will continue in the SEHP for as long as the participating Non State Employer Group is covered under the Plan. If a participating Non State Employer Group elects to terminate coverage in the SEHP, the Direct Bill members from that Non State Employer Group would be terminated as well. It is the responsibility of the Non State Employer Group to contact all their Direct bill members when the NSE terminates its contract with the SEHP.

NOTE: If a retiree is hired by a participating Non State Employer Group and did not previously retire from an employer that was part of the SEHP, the retiree may not participate in the SEHP Direct Bill program upon terminating employment from the Non State Employer Group because they did not retire from the State of Kansas originally.

The following members are eligible to continue under the SEHP Direct Bill Program:

Subject to the provisions of subsection (e) of K.A.R. 108-1-3 and 108-1-4, the classes of persons eligible to participate as members of the SEHP on a Direct Bill basis shall be those classes of persons listed below:

A. Any retired school district employee who is eligible to receive retirement benefits;

B. Any totally disabled former school district employee who is receiving benefits under K.S.A. 74-4927 and amendments thereto;

C. Any surviving spouse or dependent of a qualifying member in the school district plan;

D. Any person who is a school district employee and who is on approved Leave Without Pay in accordance with the practices of the qualified school district;

E. Any individual who was covered by the health care plan offered by the qualified school district on the day immediately before the first day on which the qualified school district participates in the school district plan, except that no individual who is an employee of the qualified school district and who does not meet the definition of school district employee in K.A.R 108-1-3

F. Any retired local unit employee who meets one of the following conditions:

1) The employee is eligible to receive retirement benefits under the Kansas Public Employees Retirement System or the Kansas police and firemen's retirement system; or

2) If the qualified local unit is not a participating employer under either the Kansas Public Employees Retirement system or the Kansas police and firemen's retirement system, the employee is eligible to receive retirement benefits under the retirement plan provided by the qualified local unit;

G. Any totally disabled former local unit employee who meets one of the following conditions:

1) The employee is receiving benefits under the Kansas Public Employees Retirement System or the Kansas police and firemen's retirement system; or

2) If the qualified local unit is not a participating employer under either the Kansas Public Employees Retirement system or the Kansas police and firemen's retirement system, the employee is receiving disability benefits under the retirement or disability plan provided by the qualified local unit.

H. Any surviving spouse or dependent of a qualifying member in the local unit plan

I. Any person who is a local unit employee and who is on approved Leave Without Pay in accordance with the practices of the qualified local unit; and

J. Any individual who was covered by the health care plan offered by the qualified local unit on the day immediately before the first day on which the qualified local unit participates in the local unit plan, except that no individual who is an employee of the qualified local unit and who does not meet the definition of the local unit employee in K.A.R. 108-1-4.

II. CONDITIONS FOR DIRECT BILL MEMBERS

Each person who is within a class listed above will be eligible to participate on a direct bill basis only if the person meets both of the following conditions:

1. The person was covered by the qualified school district plan or the health care insurance plan offered by the qualified school district on one of the following bases:

a) Immediately before the date the person ceased to be eligible for coverage, or for any person identified in paragraph E. above immediately before the first day on which the qualified school district participates in the school district plan, the person either was covered as an active member or was covered by the health care insurance plan offered by the employee's qualified school district.

b) The person is a surviving spouse or dependent of an active or Direct Bill member who was enrolled when the primary member died, and the person was enrolled in the health care benefits program as a dependent when the primary member died.

c) The person is a surviving spouse or dependent of a primary member who was enrolled under the health care insurance plan offered by the member's qualified school district when the member died, and the person has maintained continuous coverage under the qualified school district's health care insurance plan before joining the health care benefits program.

2. The person completes an enrollment form requesting transfer to the Direct Bill program and submits the form to the SEHP. The form must be submitted no more than 30 days after the person ceased to be eligible for coverage, or in the case of any individual identified in paragraph E. no more than 30 days after the first day on which the qualified school district participates in the school district plan.

3. The person was covered by the qualified local unit plan or the health care insurance plan offered by the qualified local unit on one of the following bases:

a) Immediately before the date the person ceased to be eligible for coverage, or for any person identified in paragraph J. above immediately before the first day on which the qualified local unit participates in the local unit plan, the person either was covered as an active member or was covered by the health care insurance plan offered by the employee's local unit.

b) The person is a surviving spouse or dependent of an active or Direct Bill member who was enrolled when the primary member died, and the person was enrolled in the health care benefits program as a dependent when the primary member died.

c) The person is a surviving spouse or dependent of a primary member who was enrolled under the health care insurance plan offered by the member's qualified local unit when the member died, and the person has maintained continuous coverage under the qualified local unit's health care insurance plan before joining the health care benefits program.

4. The person completes an enrollment form requesting transfer to the Direct Bill program and submits the form to the SEHP. The form must be submitted no more than 30 days after the person ceased to be eligible for coverage, or in the case of any individual identified in paragraph J. no more than 30 days after the first day on which the qualified local unit participates in the local unit plan.

5. Continuation of benefits (COBRA) coverage. Any individual with rights to extend coverage under provisions of public law 99-272, as amended, may participate in the school district plan, subject to the provisions of that federal law.

III. PAYMENT METHODS UNDER THE DIRECT BILL PROGRAM

Members who are eligible to continue coverage under the SEHP may pay their premiums by any of these methods:

- Bank draft (see **Appendix T**)
- Online
- Telephone
- Check or money order

A Welcome letter from the SEHP's Direct Bill premium billing vendor will be sent to the member with their first bill. This letter also outlines the above payment options available to the member.

Premium payments are due the first of the month for that month's coverage. Payment will be considered late if not received by the 15th of the month and coverage will be terminated back to the first of that month.

For additional information concerning the Direct Bill program, the NSE HR Representative or the member should contact:

Membership Services
State Employee Health Plan
Room 900 – Landon State Office Building
900 SW Jackson Street
Topeka, Kansas 66612-1220
Telephone: 1-866-541-7100 (Toll Free)
785-296-1715 (In Topeka)
Fax: 785-368-7180

IV. RETIREMENT, SEHP BENEFITS AND MEDICARE ELIGIBILITY

A. RETIREMENT

When an employee decides to retire, **the employee** needs to take the following steps:

1. Notify their Non State Employer of their date of retirement at least 90 days before the effective date.
2. Decide if they wish to continue with the SEHP coverage after retirement.

   NOTE: Retirement is considered a termination of employment and therefore makes the primary member and their covered dependents eligible to continue their SEHP coverage under COBRA. The primary member and their covered dependents will automatically receive a COBRA qualifying event notice from the SEHP's COBRA administrator (Please see **Chapter 20**, Continuation of Coverage – COBRA for further information).

   The primary member and their dependents should only choose to continue their coverage under the SEHP Direct Bill program or COBRA continuation; **not both**. If the primary member and their dependents elect to continue their SEHP benefits

under the Direct Bill program, the primary member should ignore the COBRA qualifying event notice. This prevents the primary member from being charged for 2 coverage plans.

3. If the primary member decides to enroll in the SEHP Direct Bill program and the primary member and/or spouse are Medicare eligible, they must indicate the Medicare plan they wish to enroll in.
4. If Medicare eligible, the primary member must be enrolled in both Parts of Medicare (Part A & B). If only enrolled in Part A, obtain **Appendix I** from their NSE to take to their local Social Security office to enroll in Medicare Part B.
5. If the member is electing Kansas Senior Plan C, they must determine if they wish to maintain the SEHP drug coverage. If the member does not keep the SEHP drug coverage, they need to obtain a letter of creditable coverage from SEHP.
6. Decide if they wish to maintain the SEHP dental coverage. If the member elects to opt out of dental coverage at the time of retirement, they **cannot** re-enroll in SEHP dental coverage at a later date.
7. Vision coverage may not be dropped for the primary member, their spouse or dependent at retirement or during the plan year unless a spouse or dependent becomes ineligible or unless all coverage is terminated. If dependent medical is dropped, dependent vision coverage can be dropped.
8. Include a copy of all applicable Medicare cards or a letter from Social Security indicating their Medicare number and effective dates for Medicare Parts A and B.

When an employee retires, **the NSE HR Representative** needs to take the following steps:

1. Ask the employee if they wish to continue their SEHP coverage under the SEHP Direct Bill program or COBRA continuation. If the employee wishes to continue under COBRA continuation, please refer to **Chapter 20**, Continuation of Coverage – COBRA for further information. If the employee wishes to continue their SEHP under the SEHP Direct Bill program, please continue below.
2. Ask employee if they or any covered spouse or dependent is Medicare eligible.
3. If needed, provide the employee with the **Appendix I** memo, Creditable Coverage letter, Direct Bill Enrollment booklet and charts including Medicare plan options if applicable.
4. Complete the online Change request for retirement in KEEP.
5. Indicate the medical coverage the primary member wishes to be enrolled in after retirement. Provide the primary member with their Medicare Plan Options if applicable.
6. Indicate in the note section of the online Change request if the primary member is eligible for split coverage (See Split Enrollment section below). Be sure to ask both the primary member and the dependent(s) [spouse and/or child(ren)] the medical coverage they wish to be enrolled in.
7. Ask primary member if they want to opt out of dental coverage. Remember to inform them that if they opt out of the dental coverage, they **cannot** re-enroll in the SEHP dental coverage at a later date. If the primary member elects to opt out of dental coverage, this must be indicated on the online Change request.
8. If Medicare eligible, indicate whether the primary member and dependent(s) [spouse and/or child(ren)] are continuing their SEHP drug coverage. If so, then indicate the prescription drug coverage election for the primary member and dependent(s) [spouse and/or child(ren)]. If the member elects to drop SEHP drug

coverage, this must be indicated on the online Change request.

9. Ensure that the appropriate supporting documentation has been provided by the employee and is uploaded with the online Change request. In order to match spouse and dependent documentation to the appropriate primary member, the NSE HR Representative must verify prior to sending the documentation to the SEHP, that the primary member's name, employee ID, and the NSE group Number is clearly written on top of each document.

10. Employee and Personnel Officer Authorization

The NSE HR Representative must authorize that they are entering all information in KEEP at the request of an employee of their NSE group and is complete and accurate to the best of their knowledge. They also ensure that appropriate supporting documentation is included, and that the employee agrees to the terms and conditions of the SEHP. They authorize the information submitted in KEEP will be used to determine eligibility for SEHP coverage. By this authorization they further understand that if any material information is omitted or incorrect, it could provide the basis to refuse or rescind coverage and refund any premiums paid as though coverage had never been in force

REMINDERS:

a) Effective January 21, 2001, a person will not be eligible for Direct Bill coverage if they do not maintain continuous coverage with the SEHP. This is in accordance with K.A.R. 108-1-3 and K.A.R 108-1-4.

b) Members must have continuous coverage under the SEHP to be eligible for the Direct Bill program. If continued coverage is desired, the online Change request must be completed 90 days before the employee's retirement in order to ensure continuous coverage between active employee coverage and Direct Bill coverage.

c) The employee may change their medical plan at the time of retirement. Dependents may be dropped from coverage upon retirement; however, dependents may be added to coverage mid-year only if there is a qualifying event (see **Chapter 12**). Dependents may also be added to coverage during the next Open Enrollment period.

d) The employee has the option to opt out of dental coverage at the time of retirement. If the employee chooses to opt out of dental coverage, the employee will not be allowed to enroll in dental coverage at a later date. Retiring employees can only drop dependent dental coverage if the dependent is being dropped from medical coverage. Otherwise, dependent dental coverage may only be dropped at Open Enrollment.

e) Vision coverage may not be dropped at retirement or during the plan year unless due to a dependent becoming ineligible or unless all coverage is terminated. If dependent medical coverage is dropped, dependent vision coverage can be dropped.

f) The effective date of change to the Direct Bill program will be the first day of the month following the employee's last day in pay status. The SEHP's Direct Bill premium billing vendor will send a Welcome letter to the member with their first bill for the first full month of Direct Bill premiums. This letter also outlines the payment options available to the member.

B. EMPLOYEES, SPOUSES AND/OR DEPENDENTS WHO ARE MEDICARE ELIGIBLE AT RETIREMENT

If the employee or covered spouse/dependent is Medicare eligible when the employee retires, they must have or need to apply for Medicare Part A and Part B. The Social Security Administration requires that the NSE provide retiring employees a memo or letter with health insurance information necessary to process the application for Medicare Part B coverage. When applying for Medicare Part B, the NSE needs to complete **Appendix I** for the employee to present to their local Social Security Office. A sample format is found in **Appendix I** and contains the required information. Please note the letter or memo should be on the Non State Employer's letterhead

Required information in the memo or letter is:

1. Statement that the employee is covered under the SEHP
2. Date coverage began
3. Date coverage ended or will end
4. Spouse's name and Social Security Number if the spouse is covered by the SEHP

C. SPLIT ENROLLMENT

Split Enrollment is required for the following situations:

- When the member and spouse are both Medicare eligible
- When the member is Medicare eligible and the spouse/dependents are not Medicare eligible
- When the member is not Medicare eligible and the spouse/dependents are Medicare eligible

When Split Enrollment occurs, the Medicare member(s) would enroll in one of the following plans:

a. Coventry Advantra PPO with Coventry prescription drug coverage
b. Coventry Advantra PPO with First Health Part D prescription drug coverage
c. Kansas Senior Plan C with First Health Part D prescription drug coverage
d. Kansas Senior Plan C without First Health Part D prescription drug coverage

The non-Medicare member remains in one of the SEHP's Plan A, Plan B, or High Deductible Plan C options. The Non State Employer will need to complete an online Change request indicating that the employee is retiring and wishes to continue with the SEHP Direct Bill coverage. The employee will need to complete an online enrollment via KEEP. They will indicate their coverage elections and under the spouse/dependent's information, they will indicate the coverage election for the spouse/dependents.

Information on these plans can be found on the SEHP website at:

http://www.kdheks.gov/hcf/sehp/directbill.htm

D. Death of Primary Direct Bill Member with Dependent Children

In the event of the death of a primary Direct Bill member who only had dependent child(ren) covered under their coverage, the surviving dependent child(ren) may elect to continue coverage under the SEHP Direct Bill program until they no longer meet the definition of an eligible dependent (i.e., the child reaches the limiting age of 26).

The eligible dependent child(ren) or authorized representative for the eligible dependent child(ren) must contact SEHP Membership within 31 days of the death of the Direct Bill

primary member in order to elect to continue coverage under the Direct Bill program. If elected, the Direct Bill coverage will be set up under the youngest eligible dependent child as the primary member with other eligible dependent child(ren) set up as dependents under that new primary member.

CHAPTER 19 – PREMIUM REFUNDS DUE TO DIRECT BILL MEMBER'S DEATH

I. PREMIUM REFUNDS

The primary member enrolled in the Direct Bill program, or a primary member's authorized representative is responsible for notifying SEHP Membership Services **in writing within 31 days** of a change in family status, including the death of a primary member, spouse or dependent.

If the primary member or authorized representative does not notify SEHP Membership Services within 31 days of a change in family status due to the death of the primary member, spouse or dependent, their premium recovery is limited to the following:

- If SEHP Membership Services is notified after 31 days but within the first 6 months of a death, the member will be eligible to receive a premium refund equal to 95% of the actual monthly premium paid by the member.
- If the SEHP is notified after 6 months but prior to 12 months of a member, spouse or dependent's death, the member is eligible to receive a premium refund equal to 95% of the actual monthly premium paid by the member for the first 6 months, plus a premium refund of 50% of the actual monthly premium paid by the member for months 7, 8, 9, 10, 11 and 12.

(Example: If a member's monthly premium payment is $200.00 per month and the SEHP is notified in writing in the 8th month after a death, the member would receive a premium refund of 95% of the actual monthly premium paid by the member for the first 6 months and a premium refund of 50% of the actual monthly premium paid by the member for months 7 and 8 for a total refund of $1,340.00)

- If the SEHP is notified after the 12th month of a member, spouse or dependent's death, the member will not be eligible for any premium refund.

CHAPTER 20 – CONTINUATION OF COVERAGE - COBRA

I. COBRA CONTINUATION

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) law was enacted in 1986. The law requires that most employers sponsoring Group Health Insurance Plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end.

Employees, their spouses and dependents that lose insurance coverage under the SEHP have the right to elect to continue coverage by paying the required premiums themselves. (Under COBRA, retirees and those covered through the Direct Bill program have the same continuation rights as active employees.). If a retiree has chosen COBRA over the SEHP Direct Bill coverage and COBRA runs out, the retiree may enroll in Direct Bill coverage.

COBRA continuation is administered through the SEHP's third party COBRA administrator.

Former employees, spouses and dependents eligible to continue health insurance coverage are called **Qualified Beneficiaries**. The provisions under which they can continue coverage are called **Qualifying Events**. The number of months they can continue coverage is specified based on their qualifying event. The maximum length of time a qualified beneficiary may carry COBRA coverage is 18 months. Coverage may be shortened or extended in lieu of a secondary qualifying event.

II. HEALTH COVERAGE TO BE CONTINUED

Qualified beneficiaries are eligible to continue only those medical, dental, prescription drug and vision benefits for which they are covered at the time of the qualifying event.

NOTE: If an employee goes on Leave Without Pay, then terminates employment AND does not continue SEHP coverage during the leave period, then that employee and any dependents would **NOT** be eligible for COBRA continuation. They are not eligible because they were not participating in the SEHP at the time of the qualifying event.

III. PROCEDURES TO BE FOLLOWED WHEN EXPERIENCING A COBRA QUALIFYING EVENT

A. If the qualifying event is termination of employment (except for gross misconduct), the SEHP notifies the member's medical plan that termination of insurance coverage has occurred. Because there is a time limit in which the qualified beneficiary can elect to continue coverage, the NSE must enter terminations of employment immediately in KEEP so that SEHP Membership Services can cancel coverage.

B. If the qualifying event is the reduction of hours of work to less than 1,000 per year, the SEHP notifies the member's medical plan that termination of insurance coverage has occurred. The online Change request has been designed so that this information can be submitted by the NSE HR Representative via KEEP. Because there is a time limit in which the qualified beneficiary can elect to continue coverage, upon completion, these online requests must be immediately submitted to SEHP Membership Services.

C. If the qualifying event is because of

1. Death of covered employee (active employee & Direct Bill).

2. Divorce from covered employee (active employee & Direct Bill).

3. Covered employee chooses Medicare as primary carrier leaving dependents without health insurance coverage (active employees ONLY), or

4. Cease to meet the SEHP's definition of dependent, i.e. turns age 26 (active employee & Direct Bill):

The qualifying beneficiary must notify the NSE HR Representative of the employee's NSE **within 60 days** of the qualifying event. (Spouses and dependents of retirees should notify the SEHP **within 60 days** of the qualifying event). If notice is not received within 60 days of the qualifying event, the beneficiary will **not** be eligible for continuation coverage. Because of this time limit, the NSE HR Representative must submit these change requests immediately to SEHP Membership Services.

D. Within 21 days of SEHP Membership Services receiving and approving the qualifying event, the qualifying beneficiary will receive specific information from the third party COBRA administrator, including a COBRA Enrollment Form setting forth the requirements for continuing insurance coverage, the plans available, and the applicable premium rates.

E. An election by a covered employee or spouse to continue coverage will be deemed to be an election for coverage by any other qualifying beneficiary. However, each qualifying beneficiary has an individual right to select continuation coverage. Each beneficiary may make a separate selection among the levels of coverage available.

IV. TERMINATION OF COVERAGE CONTINUATION

A. Non-payment or untimely payment of premiums;

B. The employee or their dependent(s) become(s) covered, either as an employee or dependent, under another employer-provided medical plan which does not limit or exclude coverage for pre-existing conditions (does **not** apply to the surviving spouse in qualifying event 1);

C. The employee or enrolled dependent(s) become eligible for Medicare (has enrolled in the Medicare program). Termination includes all medical, prescription, dental, and vision coverage. However, if Medicare eligibility is due to ESRD, the individual may continue on COBRA;

NOTE: Only the person(s) eligible for Medicare coverage lose(s) COBRA Continuation benefits. Any other person(s) enrolled may continue for the duration of the COBRA eligibility period;

D. The State of Kansas no longer offers group health insurance to its employees.

V. ADMINISTRATIVE ISSUES

A. SEHP benefits will generally terminate on the last day of the month in which the qualifying event occurs.

B. COBRA notices are generated by the SEHP's third party COBRA administrator following the NSE HR Representative entering the employee's termination request in KEEP. If the termination request is not entered into KEEP, the qualified beneficiary does not receive a letter. Therefore, timeliness becomes a critical issue when submitting termination requests in KEEP. If the termination request is not approved and processed the medical plan will not be notified to cancel coverage and claims are paid without collection of premium.

NOTE: Untimely notification has a severe adverse effect on health insurance rates.

C. COBRA continuation is not automatic; it is a choice that the qualified beneficiary must make. Also, the termination request does not activate COBRA continuation status. The qualified beneficiary must complete the COBRA election form that accompanies the

COBRA notification letter sent by the third party COBRA administrator. The qualified beneficiary has 60 days from the date of the letter to return the COBRA continuation election form to the third party COBRA administrator.

D. COBRA notification letters will be sent to the qualified beneficiary at their last known address. Therefore it is very important at the time of termination that the correct address appears in KEEP. Also, former employees should be reminded to leave forwarding instructions with the US Postal Service in the event of a change of address.

VI. COST OF BENEFITS - COBRA CONTINUATION RATES

Any qualified beneficiary who elects to continue coverage under the plan must pay the full cost of that coverage (including **both** the share they paid as an active employee, and the share the NSE paid as the employer), **plus** any additional amounts allowed by law. At present, COBRA Continuation rates are 102% of total premium. However, those beneficiaries who elect the 11-month extension of benefits due to disability will pay 150% of premium for the additional 11-months of coverage.

For the current Plan Year COBRA rates, see **Appendix Q** or go to the SEHP web site at: **www.kdheks.gov/hcf/sehp/COBRA.htm**

CHAPTER 21 - APPEALS FOR EXCEPTION DUE TO NON STATE EMPLOYER GROUP ERROR

I. APPEALS FOR EXCEPTION DUE TO NON STATE EMPLOYER GROUP ERROR

Submission of online requests for Enrollments and Changes to the SEHP in a timely manner is extremely important. Many enrollment options or enrollment changes are available without restriction for only a limited amount of time from a specific date or occurrence of an event. Any requests not received by SEHP Membership Services within the specified time frames will result in denials or significant restrictions being placed on the employee's enrollment options.

The majority of policies use event date, date submitted and date received by SEHP Membership Services as the determining dates for timely notification. It is the responsibility of the NSE HR Representative to ensure that appropriate requests are submitted in KEEP correctly and the appropriate documentation is submitted in such a way that documents are **received** by SEHP Membership Services within the necessary time frames.

If the employee notifies their NSE HR Representative of their request for enrollment or change and the NSE HR Representative fails to submit the requests online before the deadline to SEHP Membership Services, the employee will be penalized. Appeals for exception due to Non State Employer Group error shall also include circumstances in which NSE HR Representative provided inaccurate health plan information to the member and the member detrimentally relied on said incorrect information. If the Non State Employer Group chooses to appeal any restrictions or denials due to Non State Employer Group error the NSE HR Representative should:

1. Write a letter to SEHP Membership Services on NSE Group letterhead, appealing the denial or restriction that was due to NSE Group error. The letter must include:
   - The name and SSN of the employee in question;
   - Copies of documentation and changes requested by the employee;
   - The nature of the error; and
   - Any steps the NSE Group has taken to prevent a reoccurrence of the error.
2. A letter is required for each employee. Acknowledgment of NSE Group error does not provide a blanket exception for all similar circumstances.
3. The appeal must be made by the NSE Group within 10 days following notification of a denial.

If SEHP Membership Services approves the appeal the NSE Group may be fined up to $1,000 per incident.

CHAPTER 22 - QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN WITH HEALTH SAVINGS ACCOUNT

I. QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)

The Qualified High Deductible Health Plan (QHDHP) is a Preferred Provider Organization (PPO) with a Health Savings Account (HSA) feature. With the QHDHP-HSA, there are both network and non-network pricing structures for health coverage. A QHDHP also provides broader nationwide services and there is an allowance for preventive care. While the Preferred Drug List (PDL) is the same for all plans, the amount the member pays will vary depending on the plan that is selected as explained below. Under Plan C, the member is responsible for all expenses until they reach the annual health plan deductible. This means that until the member reaches the health plan deductible, the member must pay 100 percent of the discounted cost for medical expenses and prescription drugs. A member can use the funds in their HSA toward these costs.

When a member chooses dependent coverage, the entire single coverage deductible must be met before claims are paid for any one individual. Most covered services are subject to the deductible, including prescription drug expenses (dental and vision expenses do not accumulate toward the medical/prescription drug deductible). See the Health Plan Comparison Chart to see the deductibles for Plan C. Preventive care services are covered in full as long as the member utilizes a Network Provider.

Prescription drugs are subject to the QHDHP deductible; the vendor ID card will carry the Caremark logo for purchase of medications at a pharmacy. The QHDHP PDL is the same as the other SEHP health plans. In addition, the QHDHP preferred drug plan is now considered as creditable drug coverage with Medicare effective with Plan Year 2013. In other words, if a Medicare eligible individual is enrolled in the QHDHP plan, they would not incur a penalty when enrolling in a Medicare Part D prescription drug plan.

II. HEALTH SAVINGS ACCOUNT (HSA)

An HSA is a required part of the QHDHP and has minimum and maximum contribution limits. The purpose of the HSA is to allow members to put tax advantaged savings aside for future medical expenses. The savings may be used for certain premiums, copayments, coinsurance, deductibles or any medical expenses that are not covered by the QHDHP.

The HSA is owned by the member, administered by the HSA Bank, and can be funded up to the maximum amount determined by the U.S. Treasury Department each year. Members who are age 55 and older can make a “catch up” contribution as outlined in IRS Publication 969 of up to $1,000 each year. Unlike an FSA, the HSA account is portable and funds rollover from year to year. The funds in the account belong to the member (account beneficiary) and unused funds rollover from year to year.

New employees who enroll in the QHDHP must complete their election online in the KEEP system within 31 days of their date of hire. Members will automatically have their HSA set up by the corresponding bank.

Members may change their HSA contribution during the plan year without a qualifying event.

If an employee changes from member only to member and dependent medical coverage or from member and dependent to member only medical coverage mid-year due to a qualifying event, the member may also change the HSA contribution amount. In some instances the contribution amount will have to change. Refer to the Heath Savings Account Contribution Chart in the Health Plan Summary Booklet. An online change request must be submitted via

KEEP to change coverage level.

NOTE: NSE Employer Groups have the option of contributing the full annual employer contribution to each Plan C members HSA up front or to continue depositing the employer contribution during each pay cycle as it is currently handled now.

ACRONYM GLOSSARY

ACH – Automated Clearinghouse Network

ARRA – American Recovery and Reinvestment Act of 2009

COBRA –Consolidated Omnibus Budget Reconciliation Act

DOL – United States Government Department of Labor

ESRD – End Stage Renal Disease

FMLA – Family Medical Leave Act

FSA – Flexible Spending Account

HIPAA – Health Insurance Portability and Accountability Act

HSA – Health Savings Account

HP – Hewlett Packard

ID Cards – Identification Cards

IRS – United States Government Internal Revenue Service

ITIN – Individual Tax Identification Number

K.A.R. – Kansas Administrative Regulation

K.S.A. – Kansas Statute Annotated

LWOP – Leave Without Pay

MHPA - Mental Health Parity Act

MSP – Medicare Secondary Payer

NMHPA - Newborns' and Mothers' Health Protection Act

NSE – Non State Employer

PPO – Preferred Provider Organization

QHDHP – Qualified High Deductible Health Plan

SCHIP – State Children's Health Insurance Program

SEHP – State Employee Health Plan

SSN – Social Security Number

TEFRA – Tax Equity and Fiscal Responsibility Act

TPA – Third Party Administrator

TTD – Temporary Total Disability

WHCRA - Women's Health and Cancer Rights Act

Appendix	Appendix Title
A-1	Kansas Administrative Regulation 108-1-3
A-2	Kansas Administrative Regulation 108-1-4
B	SEHP Enrollment Form
B-1	SEHP Enrollment Form Key
B-2	SEHP Enrollment Form Instructions
C	SEHP Change Form
C-1	SEHP Change Form Key
C-2	SEHP Change Form Instructions
D	SEHP TEFRA Form
D-1	SEHP Sample TEFRA Form Letter—Employee Age 65
D-2	SEHP Sample TEFRA Form Letter—Spouse Age 65
E	SEHP Request for Waiver of Thirty Day Waiting Period
F	SEHP Health Plan Communication Form
G	SEHP Prescription Drug Advance Purchase Certificate
G-1	SEHP Prescription Drug Advance Purchase Policy
H	SEHP Caremark Prescription Reimbursement Standard Claim Form
I	SEHP Sample Non State Employer Medicare Part B memo
J	SEHP End State Renal Disease Questionnaire
K	SEHP Dependent Grandchild Affidavit
L	SEHP Affidavit and Application for Coverage of Permanent and Totally Disabled Dependent Child
M	SEHP Affidavit of Common Law Marriage
N	SEHP Staff Contact List
O	SEHP Health Plan Contact Information
P	SEHP Coverage Begin Dates for Newly Hired Employees
Q	SEHP COBRA Rates
R	SEHP Specific HIPAA Authorization
S	SEHP Appointment of Personal Representative Form
S-1	SEHP Revocation of Personal Representative Form
T	SEHP HP Direct Bill ACH Form
U	SEHP Certification Form